

Mental Health Needs in Vulnerable Youth Populations

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ABSTRACT

Although the high prevalence of mental health difficulties in young people is well recognised, there is limited research examining the mental health needs of care leavers and socially disengaged young people (NEET, not in employment training or education). With youth unemployment on the rise and more young people entering the care system, their wellbeing is becoming a priority for research and policy.

A mental health screening was undertaken with 74 care leavers and 84 NEET young people ages 15 to 25. Psychometric screening tools included the Strengths and Difficulties Questionnaire (SDQ), Hospital Anxiety and Depression Scale (HADS) and the PROD screen. Focus groups provided information on the mental health literacy of young people and how this could potentially hinder help seeking behaviour. Lastly, a mental health training course aimed at care leaver staff was evaluated through pre and post-questionnaires and telephone interviews.

Results indicated that care leavers and NEET young people experienced significantly more mental health difficulties compared to young people in the general youth population. Emotional difficulties were the most prevalent in care leavers and peer difficulties were the most prevalent in NEET young people. Focus groups revealed that in general young people had negative attitudes about mental illness, which can in fact discourage help seeking behaviour. The staff training evaluation revealed that the LAC mental health pilot training programme was an effective way of improving staff mental health literacy and ultimately improving youth services.

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1 INTRODUCTION

1.1 Background to Research

The World Health Organisation (2011) estimated that 20% of young people experience mental health difficulties. Several studies highlight the increased incidence of mental health disorders in young people and describe the combination and complexity of these disorders (Meltzer, et al, 2000; Kessler et al, 2007). Such findings bring attention to emerging adulthood as a period of vulnerability. Not only does the onset of the majority of lifelong or recurring mental health difficulties begin in adolescence, treatment delay can have a negative effect on outcomes (Kessler, et al, 2007; McGlashan & Johannessen, 1996; Birchwood, et al, 1997) thus adolescence and young adulthood can be a critical period for treatment. However, young people have been described as reluctant to seek professional help (Rickwood, et al, 2005), due to poor mental health literacy, attitude of service providers, stigma, self-reliance and mistrust (Jorm, et al, 1997; Gulliver, et al, 2010).

Risk factors that predispose young people to greater mental health problems have been identified as; socioeconomic disadvantage, negative life experiences and family climate (Richardson & Lelliott, 2003) all of which are increased in vulnerable young people. While considerable literature exists on the mental health of young people in the general population, young people who are more vulnerable, such as care leavers and socially disengaged youth (NEET, not in employment, education or training) are easily overlooked, with studies focusing on children in care and the general youth population. For example, a number of studies have found elevated levels of mental health problems in Looked After Children (LAC), with McCann et al, (1996) finding that 67% of LAC had mental health disorders.

Thus, the question becomes what happens when young people leave care? It has been reported that LAC have poorer physical and mental health than non care peers, furthermore when they leave care they are likely to experience negative outcomes in adulthood (Simkiss, 2012). A small amount of UK studies have investigated mental health difficulties in care leavers. Dixon (2008) found that 12 months after exiting care mental health difficulties had doubled in care leavers. Signifying that in fact, care leavers have greater mental health need than LAC. This has been attributed to young people facing immense difficulties when leaving care, such as, housing problems, low educational attainment and lack of family support (Stein, 1994; Osgood, et al, 2010). Furthermore, LAC leave care far earlier than their non care counterparts (Stein & Dixon, 2006).

For socially disengaged young people in the NEET category, research highlights several risk factors associated with this group, such as young offending, substance abuse, unemployment and early death (Scottish Executive Social Research, 2005; Coles, et al, 2010). As a result of these risk factors, studies have found increased mental health problems, behavioural problems and emotional problems in NEET youth (Benjet, et al, 2012). Unemployment, social isolation and social inactivity have been recognised as risk factors for increased mental health difficulties (Banks & Jackson 1982; Bartley, 1994). Thus, the increasing number of NEET young people in the UK is of great concern (ONS, 2013; The Princes Trust, 2014).

1.2 Rationale

Previous studies have emphasised that vulnerable groups such as LAC, care leavers and socially disengaged young people are at a greater risk of having mental health difficulties; however, most studies have focused on the mental health and well-being of LAC (McCann, 1996; Meltzer et al, 2003; Dixon, 2008; Bynner & Parsons, 2002; Coles, et al, 2010). These vulnerable groups are often described in relation to economics, social disadvantage, housing, education and legislation (Stein, 1994; Caspi, et al, 1998; The Children's Leaving Care Act, 2000; Broad, 2005; The Scottish Executive Social Research, 2005; Coles, et al, 2010; Fowler, et al, 2011). Thus, the physical disadvantage of leaving care was often prioritised over psychological and emotional disadvantage. In line with this, Stein and Dixon, (2006) found that local authorities did not have strong links with mental health services because mental health was not seen as a priority. Consequently, the area of mental health in care leavers has not received full attention. Similarly for the NEET category; economic costs, education and employment outcomes often overshadow mental health agendas (Yates & Payne, 2006). However, some studies have evidenced increased mental health need in care leavers and socially disengaged or NEET young people (Dixon, 2006; Broad, 1999; Cole, 2012). Exploring the level of mental health difficulties in these vulnerable groups will increase awareness and encourage the development of promotional and preventative strategies, especially in Birmingham; which has one of the highest rates of children in care in England (Department of Education, 2011) and where youth unemployment is high (Birmingham Commission on Youth Unemployment, 2013).

Recent policy recognises mental health difficulties in vulnerable groups as a key issue, such as the Care Leaver Strategy (2013), which stipulates that needs assessments will be carried out in order to improve mental health and wellbeing intervention strategies and reduce the health inequalities that are present. The report goes on to say that the needs of care leavers and LAC must be considered. The mental health strategy: Department of Education, *No health without mental health* (2011) aims to improve mental health and wellbeing through timely identification and more efficient health services.

1.3 Purpose of study

The primary purpose of the present study is to provide a current pathological description of care leavers and NEET young people by assessing emotional and behavioural difficulties, depression, anxiety and psychotic like symptoms, in order to inform policy, future research and reduce health inequalities. Ultimately, the more that is known about vulnerable youth, the more informed training and a preventative intervention will be.

Previous research has identified a large discrepancy between the prevalence of mental health difficulties and service utilisation (Ravens-Sieberer, et al, 2008). This indicates that many young people who need help do not receive it. Thus, exploring help seeking behaviour would be a step towards closing this gap.

With regards to the NEET category research and policy often focus on employment and education; a limited number of studies focus on mental illness within this population. Thus this study will fill the gap of mental health knowledge regarding NEET young people.

Lastly, the study will evaluate a mental health training course and support the development of a mental health strategy in Birmingham for prevention and early detection of youth mental illness.

In summary, the research aims to facilitate the development of targeted interventions and provide a baseline description of mental health in care leavers and NEET young people.

1.4 Brief methodology

A mixed methods approach was utilised for three phases of the study. Firstly, a baseline screening was conducted using self-report questionnaires to identify the level of mental health need and help seeking in vulnerable young people from different settings (Birmingham Local Authority & The Princes Trust Fairbridge Programme). A secondary school sample served as a control group from which comparisons were made with care leavers and NEET young people.

Secondly, the perceptions young people have about mental health are assessed through focus groups, in order to identify how they respond to mental health disorders.

Lastly, a mental health training course aimed at staff working with care leavers is evaluated. This will facilitate the development of the mental health training course, which can be rolled out to staff that work with vulnerable young people.

2. MENTAL HEALTH AND WELLBEING WITHIN ADOLESCENT CARE POPULATIONS

2.1 Introduction

Children in care also termed looked after children (LAC) are described as children under the age of 18 in public care who have been provided with accommodation by local authorities or are subject to a care or placement order (Department of Health, 1989, 2001; Department of Education, 2013). A child is described as in need of local authority accommodation where; there is no active parent or guardian, the child is lost or deserted or the carer of the young person is unable to provide suitable accommodation (Department of Health, 1989).

This chapter is divided into four sections; pre-care, in-care, transitions and post-care, beginning with a review of the literature on the pre-care experiences of LAC. This is followed by a discussion of the prevalence of mental health difficulties in LAC and the transitioning phase from dependence to independence. A review of the mental health and wellbeing difficulties faced by care leavers will follow and why in-care and post-care populations are more prone to mental health difficulties are explored.

2.2 Before entering local authority care

Under normal circumstances transitioning from adolescence to adulthood and negotiating the complex social, biological and cognitive changes associated with this developmental period are daunting tasks.

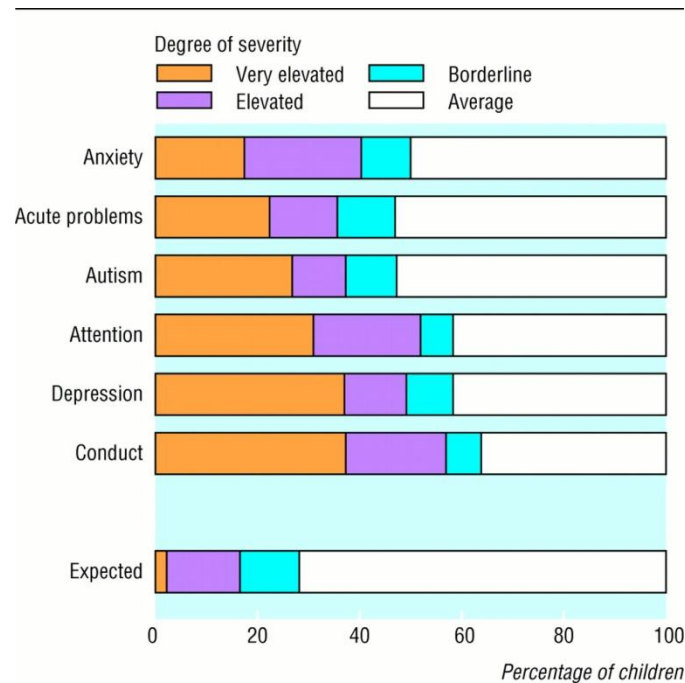
These difficulties are amplified for LAC with difficulties exacerbated by their earlier personal family and developmental experiences.

Bebbington & Miles (1989) conducted a survey in England with 2500 children admitted into care where social workers provided information on the family background of young people before they entered care. Findings indicated that 76% of those entering care were from broken homes compared with 15% of other children and that over half of children entering care lived in poor neighbourhoods compared to one third of children not in care (Bebbington & Miles, 1989). It should be noted that background information was derived from social workers and local authority records, thus missing records may bias sampling. Additionally, the comparative data had been collected two years earlier, thus limiting comparability. Despite these shortcomings the study succeeded in attaining complete records from ten local authorities and highlighted the degree in which family background is associated with admission into care. In support, Stanley et al, (2005) collected background data on mental health need in 80 LAC aged 5 to 16 years old and found that over half of children in the care system came from poor backgrounds with 79% of mothers and 41% of fathers' unemployed prior to their children entering care and parents were often associated with domestic violence, alcohol and substance misuse. Almost 'a third of mothers had criminal convictions and over half of these had spent time in prison' (Stanley, et al, 2005, p.242). For fathers 40% reported having a criminal conviction, 34% were previously incarcerated and 17.5% of LAC had experienced bereavement. Overall, 82.5% of the sample of LAC entered care because of abuse and neglect (Stanley, et al, 2005). More recent studies have continued to identify the complexities and issues surrounding children before entering the care system.

A Scandinavian study by Franzen et al, (2008) used national registers for Swedish children in care to examine socioeconomic background and admission into care. Findings showed that admission into care was associated with; having a single mother, low educational attainment, labour market exclusion, and lack of support. While, national data allows the investigation of long-term outcomes and avoids the biases of convenience samples, registered data provides limited information, i.e. reasons for placements were not attained. Additionally, the same factors that result in admission into care are linked to increased risk of poor outcomes; thus it is difficult to establish causal factors. However, their findings confirmed and expanded that of Bebbington and Miles (1989).

Dimigen et al, (1999) examined the prevalence of mental health difficulties in 70 children aged 5 to 12 when they entered local authority care. Within 6 weeks of being admitted the relevant carer completed the Devereux scales (see, Dimigen et al, 1999) of mental disorders for the children (Figure 2.1). Results showed that conduct and depressive disorder was the most common and severe, with children having very elevated levels of conduct disorder (35%) and depression (35%). A more recent study, outlined the common reasons identified by social workers for children entering care as; behavioural difficulties, parent unable to care, experience of violence, sexual abuse by parents, bereavement, mental health of parent, parental disability or illness, committed sexual abuse and desertion (Cousins et al, 2010).

Figure 2.1, Prevalence of mental disorders among children entering local authority care (Dimigen, 1999, p.675)



Essentially, the aforementioned studies suggest that an insecure family environment is often responsible for entry into care.

It should be stressed that most studies are associative in nature, thus assumptions about causation and prevention cannot be made. Thus, the aforementioned studies do not simply suggest that altering someone's family background will reduce entry into care. Rather, these studies point towards risk factors and associations which preventative investigations can explore in order to establish causality. Risk does not in itself cause mental health difficulties but it is an accumulation of such risks that can increase vulnerability to poor life outcomes.

The association between risks and outcomes is a complex one however, previous findings indicate that a significant number of children enter care with mental health difficulties and come from disadvantaged family backgrounds; this highlights an existing vulnerability before entering care.

2.3 IN-CARE: Prevalence of mental health difficulties in LAC

‘There were 65,520 LAC at 31 March 2011’ (The Department for Education, 2011, p.1) in England ‘an increase of 2 per cent from 2010 and an increase of 9 per cent since 2007’ (The Department for Education, 2011, p.1). Research has recognised that being in care can have a negative impact on mental health and wellbeing (Table 2.1). It seems that children in care are more likely to have experienced risk factors such as, socio-economic disadvantage, poverty and homelessness, which predispose them to developing mental health difficulties (Richardson & Lelliott, 2003).

McCann et al, (1996) examined the rates of psychiatric disorders in 134 LAC aged 13 to 17 in Oxfordshire, England where the Achenbach Child Behavior Checklist (Achenbach & Edelbrock, 1983, cited in McCann, et al, 1996) was used to identify young people at risk of mental health disorders and respondents with high scores were interviewed using the Kiddie Schedule for Affective Disorders and Schizophrenia (Chambers et al, 1985, cited in McCann, et al, 1996). They recruited a control group (n= 97), that consisted of age and gender matched adolescents who had no previous or current involvement with local authorities. Results suggested that psychiatric disorder was prevalent in 67% of LAC from Oxfordshire Local Authorities compared to 15% in a control group. Additionally, 96% of LAC in residential care compared to 57% of children in foster care reported psychiatric disorders. The most

frequent disorder among adolescents in the care system was conduct disorder at 28%, followed by anxiety disorders which were present in 26% of the sample and lastly, 23% reported major depressive disorder. In comparison, 0% of the control group reported conduct disorders, 3% reported anxiety disorders and 4% reported major depressive disorder. Additionally, 8% of the LAC sample were diagnosed with unspecified psychosis and were experiencing hallucinations. McCann et al, (1996) points out the extensive gap between LAC and their non care peers and disconcertingly highlight that although treatment was available, many of these disorders went unnoticed by local and health authorities (McCann et al, 1996). Another study found that 45 to 50% of LAC had behavioural problems, such as; low self-esteem, anger, overdosing, and self harm. In addition 34 to 39% of the sample had difficulties with adult and peer relationships (Stanley et al, 2005).

More extensive samples from the Office of National Statistics (ONS) survey reported by Meltzer et al, (2003) provide rates of mental health disorders in a sample comprised of 1039 LAC from 135 local authorities across England. Using the Strengths and difficulties Questionnaire (Goodman, 1997) and Development and Wellbeing Assessment (cited in Meltzer, et al, 2003) they assessed; conduct, emotional and hyperkinetic disorders. Among 11 to 15 year old LAC, 12% had emotional disorders compared with 6% in non care peers; 40% of LAC reported clinically significant conduct disorder compared to 6% in the non care population and 7% of LAC reported hyperkinetic disorders compared to 1% of non care children (Meltzer, et al, 2003). For LAC overall 49% reported any mental health disorder compared to 11% in controls, of children in foster care 40% reported a mental disorder compared with 72% in residential care (Meltzer, et al, 2003). The strength of the study is that it shows face validity, due to the large sample size and provides a vast amount of information on the mental

health and wellbeing of LAC. However, higher levels of mental health disorders for children in foster care were found by Clausen et al, (1998) with 82% of foster children in California reporting clinical levels of mental health problems. Typically, increased behavioural difficulties, anxiety and post traumatic stress disorder have been associated with the negative experiences in foster care youth (Pilowsky, 1995; Kools & Kennedy, 2003). In a similar vein, Blower et al, (2004) conducted a quantitative and qualitative prevalence study, with 48 LAC from the UK who underwent a psychological screening; those that scored above threshold took part in a psychiatric diagnostic interview (Kiddie Schedule for Affective Disorder and Schizophrenia-Present and Lifetime, K-SADS-PL, Kaufman, et al, 1997 cited in Blower, et al, 2004). The two stage approach meant that only cases were interviewed, consequently 20% of LAC did not take part in the diagnostic interview, thus limiting generalisability of results to the LAC population. However, results revealed that 56% of LAC displayed significant psychological morbidity and 44% were described as having a ‘definite, probable or resolving diagnosis of at least one psychiatric disorder’ (Blower, et al, 2004, p.121). Other studies (Meltzer, et al, 2003 & Blower, et al, 2004) have reported lower prevalence rates compared with McCann et al, (1996), this might be attributed to age differences between the samples and the broader exploration of disorders (i.e. Obsessive Compulsive Disorder) by McCann et al, (1996).

Other studies have assessed mental health difficulties in both LAC and care leavers, for instance, Ridley & McCluskey (2003) surveyed 116 young people, 86 in residential care and 30 care leavers using self-report questionnaires to examine depression and self-esteem, health behaviours and attitudes to services. Results indicated that the LAC and care leavers’ experienced elevated depressive mood and low self-esteem compared with non care populations and 45% of the sample self harmed. Similarly,

Cousins et al, (2010) examined mental health difficulties in LAC and care leavers. Data was collected from government databases, interviews, questionnaires and young people's case files were used to conduct an exploratory study. Social workers were asked to report any emotional and behavioural problems exhibited by participants in the previous four weeks, they reported that 6.1% of adolescents attempted suicide and 8.5% self harmed. On the teacher version SDQ social workers scored 70.3% of young people as being within the borderline (16.4%) or abnormal (53.9%) range. In stark contrast, when social workers were asked to rate young people in terms of general health, 92% rated them as having satisfactory or improved general health compared to their peers (Cousins, et al, 2010). Figure 2.2 illustrates SDQ scores in the looked after population and non care children. Increased mental health difficulties experienced by the LAC population are a consistent finding, and although social workers recognise these difficulties, they appear to overlook them (Cousins, et al, 2010). One limitation was that data collected was based on social workers views and young people did not contribute, thus underreporting may have occurred and they also noted that the SDQ is a short screening tool and more comprehensive screening may be more reliable (Cousins et al, 2010).

Figure 2.2, SDQ scores of the young people living in care compared with controls (Cousins, et al, 2010, p.503)

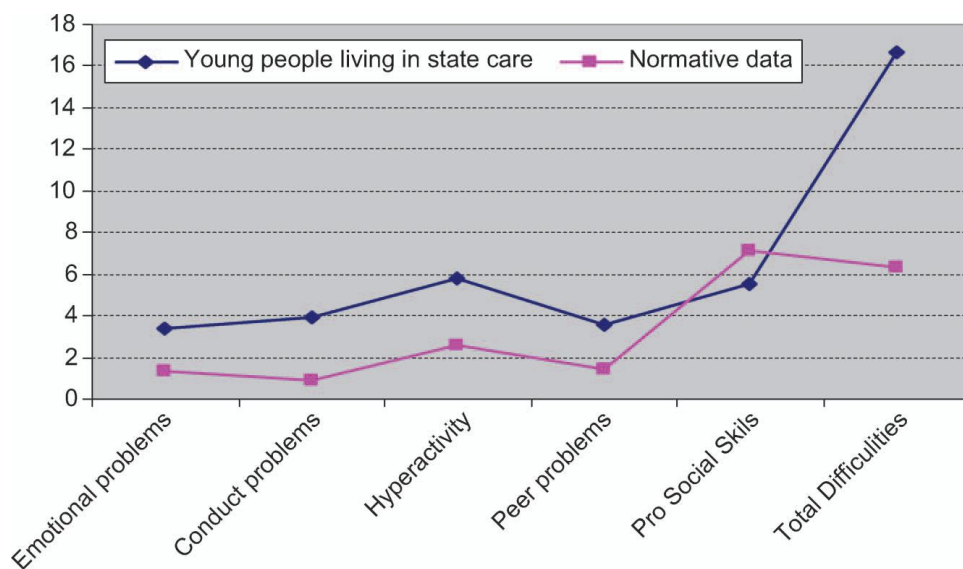


Table 2.1 Prevalence rates of mental health disorders in LAC in UK

| Authors | Country | Measures | Sample | Mental health disorder |
|---|----------------|--|------------------------|-------------------------------|
| McCann et al, (1996) | England | CBCL K-SADS (cited in McCann, 1996) | N=134 17-17yrs | 67% |
| Chetwynd and Robb (1999, cited in Kendrick et al, 2004) | Glasgow | - | N=72 12-15yrs | 56.5% |
| Meltzer et al, (2003) | Scotland | DAWBA (cited in Meltzer, et al, 2003) | N=1039 For 11-15yrs | 49% |
| Blower et al, (2004) | Scotland | CBCL Mood and Feeling Questionnaire Trauma Symptoms Checklist Youth Self-Report Questionnaire K-SADS-PL (cited in Blower et al, 2004) | N=48 7-17yrs | 44% |
| Ford et al, (2007) | Britain | DAWBA (cited in Ford et al, 2007) | N=1253 5-17yrs | 46.4% |

A limitation of prevalence studies is the difficulty in establishing how findings may have been influenced by difficulty accessing samples, particularly hard to reach samples. Hard to reach or vulnerable groups also tend to have disproportionally high attrition rates which can distort results.

Care should be taken when generalising prevalence estimates regarding mental health difficulties in LAC, as this can increase stigma. Nonetheless prevalence studies give pointers as to what services and interventions are most appropriate.

2.3.1 Emotional and behavioural difficulties in LAC

Further studies are consistent in identifying an increased level of mental health difficulties in LAC, particularly emotional and behavioural difficulties when compared with non care populations. Richards et al, (2006) found that LAC tended to rate themselves as having less difficulties compared to ratings by their carers and teachers. Rodrigues (2004) examined the case records of 136 LAC in Surrey, England and conducted telephone and face to face interviews with various stakeholders within the care system, concluding that children in care had a higher degree of health needs than their non care counterparts. The most common mental health difficulties reported by LAC were emotional and behavioural disorders which accounted for 36% of the sample, depression accounted for 3% and self-harm was reported in 1.6% of the care sample. Results from the SDQ also indicated that 44% of the LAC sample had probable emotional and behaviour disorders (Rodrigues, 2004).

Another study by Ford et al, (2007) compared LAC to disadvantaged children in the general population using the child benefit register for sampling disadvantaged children from private households.

Structured interviews were conducted with parents, children and teachers. Findings indicated that for most disorders LAC had significantly higher levels of mental health difficulties based on the ICD-10 classification of mental and behavioural disorders (cited in Ford et al, 2007), compared to children from deprived socio-economic backgrounds. On the SDQ only 9% of LAC scored within the normal range on all items, compared with, 41% of disadvantaged children and 53% of none disadvantaged

children from private households. However, the authors note that those in private households differed from LAC, thus the relationships between mental health difficulties and being in care may have been due to confounding variables. A Canadian study by Marquis and Flynn (2009) examined the wellbeing of 492 LAC age 11 to 15, by using the SDQ. Although the study may be less relevant in a UK context, findings were in agreement with previous studies suggesting that LAC reported increased difficulties compared to normative samples. More specifically, 31.6% of LAC scored in the abnormal range for total difficulties, 20.3% for pro-social problems, 24.7% for peer problems, 24.5% for hyperactivity, 25.4% for conduct problems and 15.4% for emotional problems. The SDQ was also used by Teggart and Menary (2005), they reported emotional and behavioural difficulties scores for LAC ages 4 to 16. Amongst 11 to 16 year old LAC 39.4% had total difficulties scores indicative of a probable disorder; an estimate very close to Whyte & Campbell (2008). Teggart & Menary (2005) found that from the LAC sample; 6.1% had probable emotional disorder, 33.3% probable conduct disorder and 15.2% probable hyperactive disorder. Generally, LAC had higher levels of emotional difficulties, conduct problems, hyperactivity, peer problems and were less likely to engage in pro-social behaviour, when compared to a control group from the ONS national survey (Metzler, et al, 2003; Teggart & Manary, 2005). The study by Teggart and Manary (2005) was not generalisable due to the small sample size and focus on one geographical area. However, findings were consistent with other large scale studies.

In a similar vein, McCrystal and McAloney (2010) used the SDQ to assess young people living in care. Results indicated that 60% of those in care scored in the normal range for total difficulties, 31% in borderline and 9% in abnormal range, while 79% of those living with both biological parents scored in normal range, 15% in borderline and 7% in abnormal range. The estimates for emotional and behavioural difficulties for LAC proposed by McCrystal and McAloney (2010) are lower than

estimates produced by other studies; this may be due to the small sample size and the use of self-report, as some studies argue that multi-informants yield more accurate results and young people tended to underestimate their difficulties (Goodman, 1997; Richards, et al, 2006). However, McCrystal and McAloney (2010) reached the conclusion that those in care experienced significantly more psychological difficulties compared to peers living with at least one biological parent. A summary of the aforementioned studies are displayed in Table 2.2.

Table 2.2 Probable total emotional and behavioural difficulties in LAC across studies using the SDQ (Goodman, 1997)

| Authors | Country | Measures | Sample | Probable disorder |
|-----------------------------|------------------|--------------------------------------|--|--------------------------|
| Teggart & Menary (2005) | Northern Ireland | SDQ, multi- informant | N=64 11-16yrs | 39.4% |
| Whyte & Campbell (2008) | Northern Ireland | SDQ, multi-informant | N=31 11-17yrs | 39% |
| Marquis & Flynn (2009) | Canada | SDQ, carer report | N=492 11-15yrs | 31.6% |
| McCrystal & McAloney (2010) | England | SDQ, longitudinal study, self-report | N=49 14-15yrs LAC & care leavers | 9% |
| Cousins et al, (2010) | Northern Ireland | SDQ social workers/teacher report | N=165 10-15yrs | 53.9% |

These studies emphasise that mental health difficulties are of particular concern in LAC. Dregan and Gilliford (2012) found that those in residential care experience greater difficulties such as depression, when compared to those in foster homes, it could be that care contexts play a role in wellbeing

outcomes or that children with less difficulties are more likely to be placed in foster homes. A limitation of the study is that information on LAC placements was limited and participants were from the British Cohort Study 1970, thus their experience of care would be limited to that time period. The study did however provide a vast amount of information on young people's experiences of care. Viner and Taylor (2005) went a step further to suggest that the psychological difficulties faced by LAC can be attributed to actually being in care, suggesting that entering care is a form of adversity (Viner & Taylor, 2005). What this suggests is that on entering care children not only deal with past problems, but may potentially face 'care injury' (further assaults on their mental health and wellbeing as a result of being in care).

The aforementioned studies highlight behavioural and emotional difficulties as highly prevalent in LAC, however international studies vary in terms of care structure when compared to the UK, thus findings may not be applicable to UK settings.

2.3.2 The experience of care and outcomes in adulthood

Research has shown that being in care during childhood is associated with mental health and wellbeing in adulthood. Cheung and Buchanan (1997) investigated the relation between risks of depression and social disadvantage in adults who have been in care aged 23 to 33. The Malaise Inventory (Rutter, et al, 1970, cited in Cheung & Buchanan, 1997) was used to measure tendency of developing depression and social disadvantage was characterised by; four or more children in the family, more than 1.5 persons in a room, council housing, lack of basic amenities and free school meals. Findings suggested that care

leavers continued to differ from their non care peers through adulthood, with women who had been in care twice as likely as male care leavers to have increased depressive symptoms, and both male and female care leavers had significantly higher depressive scores than non care counterparts. Overall, being in care during childhood had a more negative impact on mental health in adulthood than childhood social disadvantage. This finding does not denote that being in care is the reason for high malaise scores in adulthood, thus causation is not established. However the results suggest that in care experience is associated with poor mental health outcomes in adulthood, this association was not found for women aged 33, the reason for this exception was not evidenced. However, Buchanan et al, (2000) further emphasised that being in care coupled with social disadvantage had long term implications at age 16 and in adulthood. They investigated the psychological impact of being in care, using data from the National Child Development Longitudinal Study (cited in Buchanan et al, 2000). They found that in care experiences and social disadvantage during childhood were significantly associated with psychosocial problems at age 16 (Buchanan, et al, 2000). In addition, childhood experiences in care or growing up in a single parent household predicted psychosocial problems in adulthood for men and women with psychological difficulties at age 33 related to maladjustment at 16 years of age (Buchanan, et al, 2000). The authors highlighted the need for proper psychological preparation and adjustment in childhood and at 16 years of age.

A study by Vinnerljung and Sallas (2008) investigated long-term outcomes in 718 Swedish young people who had been in care. They found that those who had been in care had increased levels of; premature death, criminal justice involvement, hospitalisations for mental health difficulties, early parenthood and poor educational achievement at age 25, compared to non care peers. The authors note

that in Sweden young offenders are part of their child welfare system, thus this study may not be comparable to other countries, thus limiting the generalisability of findings. However, the study demonstrates the presence of sustained disadvantage as a result of being in care.

It appears that the negative effects of being in care are not limited to psychological problems, but also have an impact on socioeconomic variables, for instance, Viner and Taylor (2005) examined socioeconomic status, educational level, and health outcomes in adults who had been in care during childhood. Findings from the Malaise Inventory cited in Viner & Taylor (2005) suggested that being in care during childhood was related to poorer social class and homelessness in adulthood. However, Buchanan (1999) and Viner & Taylor (2005) found that the unfavourable effects of being in care can also decrease in later adulthood.

Other work has investigated the association between having been in care and wellbeing in adulthood. Adults who had been in care had worse outcomes in terms of depression, life dissatisfaction, self efficacy, smoking and criminal convictions (Buchanan, et al, 2000; Dregan, et al, 2011) emphasising that, admission into care during childhood had enduring negative effects of psychosocial adjustment in adulthood (Dregan, et al, 2011). More specifically, Dregan and Gulliford (2012) evaluated care experiences and their association with psychosocial outcomes including; type and length of placement, age on entering care, and emotional and behavioural traits in adulthood. Participants with care backgrounds and those without were derived from the 1970 British Cohort Study (Plewis, et al, 2004, cited in Dregan & Gulliford, 2012). It was found that children who experienced public care were at an increased risk of having emotional and behavioural difficulties at age 30 with a dose response, those

that spent longer in care had poorer well-being outcomes, suggesting that the experience of being in care its self can be associated with prolonged psychosocial disadvantage (Viner & Taylor, 2005).

The mentioned longitudinal cohort studies tended to report a high level of dropouts, which may have biased results. However, a robust finding from previous literature is that experiences in care can aggravate the propensity or duration of developing mental health difficulties. Clearly admission in to care is unable to compensate for previous disadvantage and may in fact have a negative impact on the trajectory of outcomes in adulthood (Buchanan, et al, 2000; Dregan & Gulliford, 2012), being in care was found to be a greater risk factor for developing mental health problems in comparison to social disadvantage (Ford, et al, 2007).

2.4 Transitioning out of care

2.4.1 Transitioning out of care and poor preparation

Transitioning out of care has proven challenging, as many care leavers are confronted with substantial difficulties in the major domains of life. Their family backgrounds are likely to be dysfunctional thus preventing care leavers from seeking solace from their biological family. This leaves care leavers in a precarious situation, to which they move on, struggle to survive or become a victim of circumstance.

It has been widely recognised that the process of transitioning out of care can play a role in influencing positive or negative outcomes after care. Akister et al, (2010) reviewed previous research on children in

care and their outcomes. Findings showed that early entry into care, placement stability, sense of security and family care promoted positive outcomes. International studies in America, Australia and the UK also recognise the difficulties young people face when transitioning out of care (Courtney, et al, 2001; Mendes & Moslehuddin, 2004, Stein, 2006 & Scannapieco, et al, 2007).

A Swedish study conducted by Hojer and Sjoblom (2011) argued that care leaver support services and resources were practically non-existent. They interviewed social service managers and 65 young people who had left care, finding that few local authorities had pathways or routines for leaving care.

However, interviews were not audio recorded, thus the likelihood that information was omitted from the analysis was increased. In light of this, findings indicated that just 6% of managers had information on young people's location. Additionally, 88% of manager's felt supporting care leavers was a priority, however 75% recognised that there was no formal procedure in place to support care leavers in Sweden, where most young people leave care at age 19. This was also voiced by McDowall (2011) who found that in Australia when leaving care was imminent, 31% of young people had an incomplete leaving care plan and preparations were inconsistent and sudden. Despite a small sample size of 58 young people in care and 30 young people in the control group, Nesmith & Christophersen (2014) found that young people were either overly prepared or overly underprepared for leaving care, thus exposing inconsistencies in the transition process. Longitudinal studies enlisting greater sample sizes would allow multivariate analysis and be more useful for understanding the transitioning process.

Apart from a lack of structure due to inconsistencies during the transition process, Dima and Skehill (2011) found that leaving care in Romania was often characterised by poor outcomes such as; instability and insecurity in accommodation, work, finances and relationships. They found that three years after leaving care 60% of care leavers had moved at least five times and over 75% were identified as living in poverty, around 30% were unemployed and over 50% had changed jobs at least five times. Two to four years after care 70.6% were classed as survivors, 11.7% were successful and 17.6% were unsuccessful with regards to leaving care (Dima & Skehill, 2011). Assuredly, care leavers expressed fear, lack of control and uncertainty concerning their future. Dima and Skehill (2011) discussed their findings in relation to the Bridges transition model (Bridges, 2002, cited in Dima & Skehill, 2011) which postulates that transition consists of three phases; an ending, neutral and beginning, and that during the ending phase of care young people need; communication about the process and relevant aftercare support, protection and opportunities to usher them into a new beginning, characterised by the gradual withdrawal of services. In light of this, Dima and Skehill (2011) concluded that young people are expected to go from dependence to immediate independence, without being allowed time to psychologically and emotionally process the changes and go through the phases. A limitation of this model is that such phases are not neatly separated; one can progressively move through the phases or may regress back psychologically. For example, someone may move from the new beginning phase back to neutral or back to the end phase where more affirmation and aftercare support is desired. However, Rogers (2011) found that young people felt that lack of emotional support signalled the end of care and they expressed feeling abandoned and isolated (Duncalf, 2010; Rogers, 2011). This might be explained by Driscoll (2013) who argued that being in care resembled 'busy isolation' (Driscoll, 2013, p.8), that is, young people come in contact with many people, but were unable to make

attachments or build meaningful relationships. This resulted in mistrusting services and becoming self reliant (Driscoll, 2013), which has been identified as a barrier to help seeking (Gulliver, et al, 2010).

An obvious limitation is that Swedish, Australian, Romanian and American studies mentioned are less likely to apply in the UK, due to differences in policy, procedures and legislation. However, UK studies echo international findings; Stein (2006^b, p.3) described the transiting process towards adulthood for LAC as 'compressed and accelerated'. Stein and Wade (2000) also reported that in England preparation for exiting care was limited; accommodation placements were inflexible, practical living skills were overlooked or addressed during the transition phase, close to exiting care and LAC had poorer employment outcomes and often were unprepared to leave care (Wade & Dixon, 2006).

It has been noted that 'poor preparation for leaving care was resulting in ill health,...becoming homeless, getting into debt, eating a poor diet, becoming socially isolated and excluded' (Ridley & McCluskey, 2003, p.61). Thus, preparations for exiting care are potentially an important indicator of outcomes.

A policy survey by Stein and Dixon (2006) revealed that information guides were unavailable when young people were planning to leave care in 45% of local authorities and review plans and policy statements prepared by the authorities, were not comprehensive (Stein & Dixon, 2006). Sixty percent of the care leavers surveyed did not receive a 'planned programme of preparation' (Stein & Dixon, 2006, p.415) for transitioning out of care with only 52% of the sample feeling prepared for independent living and those who left care at an earlier age were unlikely to feel prepared for independent living. Stein and Dixon (2006) succeed in presenting their findings in a UK legal and political context; although outcome data was only collected from 61 young people their findings coincide with Biehal &

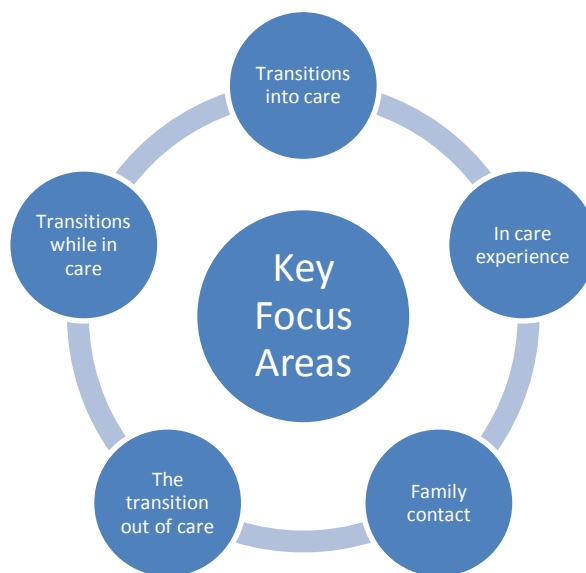
Wade (1996) who found inconsistencies between preparation for leaving care and type of care. They assessed the outcomes of UK schemes aimed at care leavers by conducting semi-structured interviews with 74 young people who were no longer in care. Findings revealed that 56% of those who left care received support from designated leaving care services; the rest had not received such support. Leaving care workers and social workers mentioned that training and preparation for leaving care was inconsistent.

Stein and Dixon (2006) reported that most young people (73%) exited care at ages 15 or 16. This is of concern because Buchannan et al, (2000) noted that being in care had negative implications at age 16. In the UK, research reports demonstrate that children in care are transitioned into independence earlier than their non-care counterparts (Biehal, et al, 1994; Broad, 1999). Broad (1999) describes that young people in the general population transition into independence at 24 to 25 years of age, LAC however, are expected to transition into independence far earlier. Generally, transitions were reported as unplanned and untimely and youth who left care early did so due to dissatisfaction with the care system (McCoy, et al, 2008).

Mullan et al, (2007) conducted six mini focus groups consisting of two to four people after in-depth interviews. The study aimed to investigate mental health and wellbeing in LAC and care leavers aged 12 to 25 and carer's perspectives were also included. Findings indicated that LAC experienced abnormal transitions and lacked a good comprehension of mental health and the care system. In addition, Mullan et al, (2007) argued that LAC 'feel very disoriented in care in relation to the reasons why they were placed in care...this disorientation can persist after they leave...to some extent the care

system reflects this disorientation with confusion about how best to meet the needs of the young person' (Mullan, et al, 2007, p.431). Mullan et al, (2007) identified five key areas for transitioning which contribute to mental health and wellbeing (Figure 2.3). However, Mullan et al, (2007) may have overly relied on youth reports by omitting insights from managers, social workers and carers, who may have provided different views about the leaving care process.

Figure 2.3, Key areas that facilitate mental health and well-being outcomes in LAC



Other research emphasise that a link exists between better preparation when leaving care and better coping, satisfaction and outcomes after care (Mendes, 2010; Stein & Dixon, 2006). Mendes et al, (2010) emphasised that leaving care plans should include; early planning, young people's participation, independent living skills training and on-going monitoring. However, Mullan et al, (2007) argued that current care plans were overly focused on education, employment and physical needs, often neglecting

psychological needs, friendships, coping skills, mentoring and placement stability. It is clear that the transitioning procedures may need improving in order to make a positive impact on mental health and wellbeing outcomes. The focus on physical and practical preparation needs would appear to warrant expansion to include greater emphasis on psychological preparation for transitioning out of care.

What these studies all appear to demonstrate is the unrealistic and unreasonable propositions presented to young people close to leaving care. They are expected to move from dependence to independence within a short time frame and without proper preparation planning and instruction (Stein & Wade, 2000; Stein, 2006). Mendes & Moslehuddin (2006) argues that the transitioning process needs to go from dependence on the care system to interdependence, rather than expecting care leavers to become independent straightaway. LAC often leave care far earlier than their non care peers, when they do leave they lack family or other support. Research findings suggest that a more gradual transition with better preparation is the key to ensuring more positive outcomes (Stein & Wade, 2000). Research may have neglected that there are exceptions in which young people are eager to attain their independence, move out of care and even disassociate themselves from the care system. Such exceptions may favour a more swift transition or may be an indicator of resilience, this aspect of transitioning requires more exploration.

Transitions often focus on accommodation, employment and education, which overshadow the fundamental role of mental health and wellbeing in sustaining positive outcomes in all these areas (Stein and Dixon, 2006). Young people need ample time to assimilate, prepare and accept the ending

period of care. Once young people have psychologically come to terms with the end of this phase in their life, moving on will be easier and more natural (Dima & Skehill, 2011). Those suffering from mental health difficulties and poorer wellbeing will certainly need more help and support in this regard. This is voiced by Stein and Dumaret, (2011) who state that promoting resilience should focus on ‘compensatory attachments, providing stability and continuity in their lives; a positive experience of education; prioritizing health and well-being; having turning points and new opportunities; and providing preparation in self-care, practical and inter-personal skills’ (Stein & Dumaret, 2011, p.2510).

These studies have been consistent in describing the transitions process as problematic; in particular the process appears to neglect health and general wellbeing. However, evidence provided is often dependant on the service young people have received and substantial differences may exist between local authorities regarding length of support young people receive, thus limiting the generalisability of findings. In spite of this, there is strong evidence from researchers and young people that suggests the transition process is far from ideal.

2.4.2 Legislation

Research has been used to inform legislation such as the Children’s Leaving Care Act (CLCA, 2000) an amendment of the Children Act (1989, cited in Department of Health, 1989). The CLCA (2000) outlines plans to improve preparations for leaving care such as; the duty to assist former LAC until age 21 or 24 in some instances and preparing pathway plans covering; education, accommodation, life skills and financial support.

Some studies have examined the implementation of the CLCA (2000), Broad (2005), analysed 52 completed questionnaires from leaving care teams. The questionnaire included information on staffing, young people and polices; and contained questions about the CLCA (2000) and how it had been implemented in four areas; education, employment or training, occupation, finances and health, of all these areas health service received the lowest ratings, with 85% of respondents reporting that prior to the CLCA (2000) health services were average or below average. Results for health services post CLCA (2000) showed little or no improvements and when respondents were asked about existing issues in local authority services, out of the 351 responses given, health issues were not mentioned.

In another study, Harris and Broad (2005) used ranked assessments to evaluate the CLCA (2000). Care leavers and care managers were required to rank services in terms of improved or worsened services. Education, employment, training and health were ranked as poorer performing areas in terms of service. Broad (2005), was able to demonstrate that legislation does not always complement practice, and emphasis should be on services targeted to individual needs. The Act certainly recognised that care leavers require more support. However, much research has continued to highlight the incredible disadvantage faced by care leavers as a result of lack of preparation and poor transitioning plans.

In response, more recent legislation aims to address these issues, such as, The Children & Young Person's Act (2008) which focuses on assessing educational needs and improving educational attainment by providing access to a personal adviser till age 25 and providing bursaries for LAC to pursue higher education. In addition, The Care Leavers Regulations (2010) provides information and

guidelines to local authorities regarding young people who are no longer looked after. The regulation provides a framework for local authorities, which was implemented in April, 2011 and stipulates that, young people should be involved in pathway planning and their preferences and views sought; plus personal advisors are expected to keep informed about 'former relevant' young people (The Care Leavers Regulations, 2010, p.6) and provide assistance with education and suitable accommodation. Pathway plans are to include assistance with education, employment, accommodation, social networks, personal development, financial support and health needs. These regulations compliment the National Institute for Health & Care Excellence, PH28 (2010) which provides recommendations for promoting mental health and wellbeing in LAC such as; promoting stable placements, encouraging educational aspirations, support transitions, tailor services to individual needs and include LAC in design and implementation of services.

Despite progressive change in legislation, research has exposed several weaknesses, namely that legislation lacks impact on practice and has had little or no improvements concerning health issues. These legislations and recommendations are expected to provide standards of practice, however to be implemented effectively the day to day knowledge and execution of such guidelines need to be monitored.

2.5 POST-CARE: The mental health and wellbeing of care leavers

2.5.1 Challenges after care

It would appear that, the accumulation of disadvantage prior to care, and in-care manifest after care, leading to severe and enduring difficulties, especially when there is inadequate preparation for transitioning out of care (Stein & Wade, 2000; Ridley & McCluskey, 2003; Viner & Taylor, 2005; Stein & Dixon, 2006).

Biehal and Wade (1996) described the process of transitioning out of care into independence as rushed as within 18 to 24 months of leaving care young people often had to negotiate entering the workforce, building a home, building relationships and parenthood (Biehal & Wade, 1996). Young people were not prepared for leaving care and on leaving care were immediately faced with challenging circumstances leading researchers such as Mendes et al, (2011) to describe care leavers as one of the most disadvantaged populations. Duncalf (2010) further highlighted challenges faced by care leavers through an online survey, completed by care leavers aged 17 to 78. Findings showed that 22% of care leavers mentioned having poor accommodation, 18% had experienced homelessness and 20% had no support. Although issues such as internet access may have reduced representativeness, the online approach did encourage their sample size of 310 care leavers. Findings suggest that unfavourable circumstances await young people when they leave care and potentially continue into later adulthood.

2.5.2 Family support after leaving care

A study by Hojer and Sjoblom (2010) examined experiences and perceptions of 16 care leavers aged 18 to 22 transitioning out of care using semi-structured interviews. Care leavers had entered care due to parental issues, such as; drug, alcohol abuse, mental illness, behavioural issues and family conflict. To ascertain social networks; social workers, residential staff, foster carers and birth parents took part in telephone interviews. Results indicated that families were often unable to provide post care support and were often dysfunctional with 12 of the 16 participants having no contact with their birth parents. A reason for this was explored by Franzen and Vinnerljung (2006) who conducted a large-scale study on parental death in foster children. They found that 'At age 18, 13-15% of all foster care youths were motherless or orphans, compared to 1% of their peers who had never entered foster care' (Franzen & Vinnerljung, 2006, p.261). Additionally, they found that the majority of parental death was as a result of substance misuse, violence and suicide. The research was based on quantitative analysis and birth cohorts of young people, thus the study would benefit from qualitative investigations which include the experiences and perspectives of young people, to supplement quantitative findings. However, the study succeeds in identifying parental death as an additional risk factor for admission into care and highlights the lack of parental support available to young people who have been in care.

Alternatively, McCoy et al, (2008) found that most youth who left care moved in with family, many studies suggest otherwise, Osgood et al, (2010, p.212), argued that 'most young people begin their transition to adulthood from the security of their family's home, runaway and homeless youth and youth leaving foster care may have to find their own housing...youth in the general population typically

receive valuable support from their families, and even when they do not, they know it would be forthcoming were a special need to arise’.

On the whole, care leavers do not have much to fall back on forcing them into a state of survival or helplessness a concept described by Stein (2004, p.41-42) who argues that care leavers are a heterogeneous group who are likely to fall into one of three categories after leaving care, these include the; ‘moving on group’, ‘survivors’ and ‘victims’. The moving on group were more likely to have security and stability in care, look forward to independence and utilise available support, thus Stein (2004) described them as the most resilient group. Stein described the second group as survivors; young people likely to have experienced a lot of instability but for whom the efficacy of leaving care support services influenced positive outcomes. Lastly, the victims group have had increased negative pre-care experiences and consequently, experience greater difficulties, which after-care services are unlikely to address. This puts an incredible amount of pressure on carers to ensure security and stability in order to cultivate resilience in young people. However, young people with highly negative pre-care experiences are more likely to be emotionally or psychologically unstable when they enter care. Undoing such pre-care instability would be difficult and such young people are likely to remain victims.

2.5.3 Difficulty building relationships

Another consideration is that after care, care leavers face an uphill struggle to build healthy relationships, for example, Gaskell (2010) conducted informal interviews with 10 young people who had been in the care system, findings suggested that care leavers have a ‘dominant attachment pattern’ (Gaskell, 2010, p.142), of getting accustomed to their needs not being met. Gaskell (2010) exposes the importance of youth being listened to, having a voice, and creating trusting relationships. A limitation of the study is that interviews were not audio recorded, thus all the information may not have been collected. In addition, interviews took place in public settings; where young people may not have been comfortable disclosing personal information. A similar study conducted 60 in depth interviews with youth formally in American state care, finding that mistrust was present and often hindered young people from seeking help; ‘repeated unfavourable experiences undermine trust’ (Munson, et al, 2011, p.2265). It appears that care leavers struggle to build relationships due to inconsistencies between anticipated support and actual support. Further investigations on the quality of relationships and relationship formation would provide additional information about the nature of care leaver relationships and social networks, which can inform future interventions.

2.5.4 Post-care accommodation

Research has often found accommodation and education to be priorities for intervention in reducing the disadvantage faced by care leavers and LAC. Ward and Pearson (2003) noted that accommodation was a priority for youth and participation in education, employment and training was often secondary. Young people mentioned a lack of commitment and inability to face the challenges which came with

education and employment, plus accommodation was often at the forefront of their minds (Ward & Pearson, 2003). This is not surprising as Stein and Morris (2009) reported that being in safe and suitable accommodation was associated with increased wellbeing and involvement in education, employment and training. Despite this, two years after leaving care 15% of young people had experienced homelessness (Biehal et al, 1994), related to increased number of moves and leaving care early.

After leaving care many young people became unstable, Biehal et al, (1994) found that 50% of those who left care had moved two or more times and one sixth of the sample had moved five or more times. It is clear that such instability transfers to other domains of life, such as; work, housing and further education (Stein, 1994). It is possible that continuous instability in young people's lives can create a state of restlessness, which if not addressed, can make it difficult to maintain good outcomes and relationships (Mullan, et al, 2007; Driscoll, 2013). Equally, Stein and Dixon (2006) found that, from young people's surveys, instability was prominent, with a third of the young people being moved at least four times.

A longitudinal study by Cashmore and Paxman (2006) exposed the gross instability care leavers face, by interviewing 47 young people in Australia within four to five years of their leaving care, measuring continuity of care and stability and security amongst other outcomes. The authors found that young people who were insecure had experienced a greater level of instability with up to 9.5 placements. In comparison secure young people had on average 2.3 placements. It was argued that emotional stability was associated with stable and consistent accommodation in and after care and that young people who

were stable and secure had more social support. However, the study may have underestimated the number of moves when compared to the UK, because most young people in the study left care at 18, however in the UK the majority of young people leave care at 15 or 16 (Stein & Dixon, 2006). Fowler et al, (2011) however, stresses the importance of stable accommodation and participation in education and employment in order to maintain positive mental health in care leavers. Fowler et al, (2011) evaluated 265 care leavers ages 19 to 23 a few years after leaving foster care, information was collected regarding; past experiences of housing, security, education, employment and mental health, which encompassed; emotional distress, substance abuse and deviancy. Analysis revealed three categories of care leavers; forty one percent of the sample were described as 'stable engaged' as they were in secure accommodation and had links with education or employment, 30% of the sample were 'stable disengaged', meaning they had accommodation however were limited in their involvement with education and employment and 29% of care leavers were identified as 'instable disengaged' having experienced significant housing instability and declining or diminished links with education and employment (Fowler, et al, 2011, p.342). Overall, they found that care leavers with stable accommodation and connections with employment or education fared better than care leavers with unstable accommodation and limited links with education or employment.

Findings from research studies have recognised that accommodation and stability is associated with mental health and wellbeing in care leavers. Wade and Dixon (2006) argued that continuous instability was linked to poorer outcomes, with accommodation most commonly associated with mental health and wellbeing. They reported findings from the Department for Education and Skills (2003, cited in Wade & Dixon, 2006) for 106 young people aged 16 to 18 that had left care. They reported that, after

leaving care, 35% had experienced homelessness; however 51% had good housing and 31% said they had support in terms of accommodation. Young people who experienced poorer housing situations were likely to have mental health difficulties and disabilities, thus there is still scope for improvement.

These studies may have underestimated difficulties as those with increased instability are difficult to access due to their transient lifestyles. Cashmore and Paxman (2006) argue that more attention should be given to young people for whom the probability of experiencing poor accommodation outcomes is high. Additionally, some studies employed retrospective methods to collect data on circumstances and housing, thus data was susceptible to memory bias. However, the use of multi-informants and longitudinal designs employed in other studies has confirmed findings. Taken together, studies have highlighted accommodation as a key area of concern for care leavers.

2.5.5 Educational outcomes

In terms of education, Stein (1994) showed that 54% of care leavers left school without qualifications and 72% of LAC in residential care had no qualifications, compared with 52% of those in foster care. Overall educational underachievement is far greater in the care population than in non care populations, with Stein and Dixon (2006) finding that nearly 72% of young people who had left care reported being excluded from school. Truancy was also reported by 83% of care leavers, while, 51% frequently engaged in truancy. Poor educational performance and participation may be attributed to the constant disruption many young people face in-care, according to Stein (1994) who identified an association between poor educational attainment and placement moves and concluded that education and

placement stability should be prioritised. These conclusions were also voiced by Biehal et al, (1994); they conducted a survey on young people planning to leave care in three English local authorities. Information on age of leaving care and after care support were collected from 183 care leavers and social workers , who completed questionnaires up to nine months after young people left care. Results indicated that almost a quarter of young women experienced early parenthood of which 83% had no qualifications. Although information collected was based on the views of social workers, social workers play an integral role during transitioning out of care (Biehal, et al, 1994) in addition; the survey illustrated an association between placement instability and poor educational attainment (Biehal, et al, 1994). It is likely that these poor educational outcomes transcend into the labour market.

Later studies reached similar conclusions, Jackson and Martin (1998) used postal questionnaires to examine the experiences of 105 young people who had grown up in-care, young people with 5 or more GCSE's grade C and above or those in higher education were selected for interviews (n=38). The authors found that self-esteem was low for all care leavers; however the high achievers exhibited protective factors (Table 2.3), it appears that the care system has difficulty cultivating these protective factors. Thus high achievers or resilient young people may exhibit innate qualities such as motivation, determination and interests which encourage educational success and subsequently result in better life outcomes. Jackson and Martin (1998) concluded that educational engagement should be a priority and is needed to prevent social exclusion.

Table 2.3 Factors influencing outcomes in LAC and care leavers across studies

| Author | Protective Factors |
|---------------------------------|---|
| Jackson & Martin (1998) | Stability and continuity Early literacy Friends outside care doing well academically Interests and hobbies A role model School attendance Self-esteem |
| Cashmore & Paxman (2006) | Social support Behaviour problems Transitions Age on leaving care Continuity of accommodation |
| Buchanan (1999) | Educational support Employment support Less smoking & drinking Positive relationships |
| Stein & Dumaret (2011) | Life history Placement process |
| Nesmith & Christophersen (2014) | Learning to build relationships Supportive adults during transition Understanding trauma Empowerment |

In sum, research on young people leaving care highlights the central importance of accommodation and educational outcomes. Aftercare accommodation is often poor and temporary, making it difficult for care leavers to build a solid and stable foundation (Wade & Dixon, 2006). A basic education is a prerequisite to equip young people with tools and skills which allow them to benefit from vocational training opportunities (Stein, 1996; Jackson & Martin, 1998), however, educational attendance and subsequent academic attainment is generally poor for care leavers (Stein, 1996).

2.6 Mental health needs of care leavers

Mental health research with care leavers has been some-what overshadowed in favour of more traditional areas of concern, such as accommodation and education (Stein & Dixon, 2006). In addition many studies focus on mental health in LAC (McCann et al, 1996; Meltzer et al, 2003), but a growing body of research has documented mental health problems in care leavers (Table 2.4).

Barth (1990) conducted interviews in San Francisco with 55 young people who had left foster care at age 16. The interviews were designed to describe young people's life experiences across several key themes including; employment, contact with foster family and birth families, health and health care usage, drug use, offending, housing and income. An overall adjustment score was employed for the analysis and young people's feedback and satisfaction were also assessed; findings regarding health and wellbeing revealed that 53% of foster care leavers rated themselves as being in good health, while 13% reported being hospitalized for an emotional difficulty (Barth, 1990). The entire sample reported high depression scores, related difficulties or having spent time in a mental health hospital. The most frequent mental health problem mentioned by care leavers was depression and problems with sleeping and weight. Additionally, high suicide risk was reported by Broad (1999) who investigated the mental health difficulties in 47 young people leaving care in England, finding that 17% of young care leavers had mental health disorders, 60% experienced suicidal thoughts and 40% attempted suicide. It is possible that prevalence figures were underestimated as Broad (1999) enlisted young people as interviewers, stating that care leavers would be more comfortable talking to peers. However, this may not always be the case, as other studies have mentioned increased relationship difficulties and trust

issues in care leavers (Munson et al, 2011). Nevertheless, it has been found that children in long-term foster care or adopted children were at high risk of suicide or ‘avoidable death’ (Hjern et al, 2004, p.414).

Despite these findings, focus groups have revealed that young people found mental health services ‘stigmatising and threatening’ (Broad, 1999, p.46). Ridley and McCluskey (2003) facilitated focus groups with 14 to 24 year olds on self-esteem and depression, finding that young people’s concept of health was limited to physical health. Results also indicated significantly higher levels of depressive mood, low self-esteem and self harm compared to non care populations. This finding was confirmed by Buchanan (1999) who described care leavers as having lower levels of satisfaction in adulthood and at risk of increased psychological problems such as depression during adulthood, when compared to non-care counterparts.

Despite previous findings, Stein and Dixon (2006), found that 84% of local authorities reported having strong links with housing departments; however less authorities reported having links with benefits, education, career and health services. In addition, the health needs of care leavers were ranked lower in terms of priority, with less than 42% of authorities having made formal arrangements with health services to promote health and wellbeing in young people leaving care and just below 50% of the authorities had a health promotion plan. Follow ups of the young people are important for service development; however 61% of authorities were not collecting outcome information. Stein and Dixon (2006) identified the need for more focus on mental health and well-being in care leavers. Overall, over

40% of care leavers had mental health difficulties. Close to Wade and Dixon (2006) who reported that 44% of care leavers had mental, emotional and behavioural difficulties.

Dixon (2008) reported findings of a follow-up study of care leavers in UK. The follow-up involved face to face interviews with care leavers (n=106) on their mental health and well-being. Interviews were conducted three months after exiting care and again at 12 months, information was also collected from care workers. At baseline 38% of young people had physical or mental health difficulties, however this increased to 61% 12 months later. Essentially, reports of mental health problems were twice as much a year after leaving care and during the follow-up four young people had attempted suicide. The General Health Questionnaire-12 (Goldberg et al, 1997 cited in Dixon, 2008) also revealed that symptoms had increased for 41% of the sample at follow-up, revealing deteriorating mental health in care leavers; however 29% of young people showed less symptoms. The follow-up period may have been too short to recognise improvements in mental health, furthermore, risk behaviour such as substance misuse were documented and may have compounded mental health difficulties (Mauders et al, 1999; Dixon, 2008). Generally, mental health and wellbeing worsened after leaving care, thus suggesting that LAC become more vulnerable after care. Although the follow up period was relatively short, this study succeeds in providing valuable information on the extent of mental health difficulties present in young people that have left care.

A US study performed by Pecora et al, (2009), also reported disproportionately high rates of mental health difficulties in foster care leavers compared to non care populations. Foster care leavers were

found to have greater mental health difficulties compared with those still in care, suggesting that the complexities of graduating out of care amplify mental health difficulties (Pecora, et al, 2009). It appears that although in-care experiences have an impact on mental health, preparation is key, as several other studies have found that good preparation was associated with more successful transitions out of care (i.e. Stein & Dixon, 2006; Wade & Dixon, 2006; Mendes, 2010).

Table 2.4 Mental health disorders in care leavers, UK studies

| Authors | Country | Measures | Sample | Mental health disorder/emotional & behavioral problems |
|----------------------|----------------|--|---------------------------|---|
| Broad (1999) | England | Bespoke interview schedule | N=48 *17-21 | 17% |
| Stein & Dixon (2006) | Scotland | Nation Survey & Interviews | N=107 **16.6 | 41% |
| Wade & Dixon (2006) | England | General Health Questionnaire (Goldberg & Williams 1988, cited in Wade & Dixon, 2006) | N=106 16-18yrs & 20yrs | 44% |
| Dixon (2008) | England | General Health Questionnaire (Goldberg et al, 1997 cited in Dixon, 2008) | N=106 16+ | 51% |

*most frequent age category ** Average age

Although, increased rates of depression and other mental health problems have been evidenced in care leavers, some studies have reported a decline in mental health service utilisation, for example, Courtney et al, (2001) described the experiences of foster care leavers in the USA 12 to 18 months after leaving care (n=141). A series of interviews were conducted with young people ages 17 to 18 before they left care and after care. Questions on mental health revealed that youths were less likely to receive

mental health services after leaving care, with only 21% receiving mental health support after leaving care, however, twice as many reported receiving mental health support while in-care, perhaps due to insurance difficulties (Courtney et al, 2001), nonetheless other studies have reported similar outcomes. Overall 37% of care leavers had suffered unpleasant outcomes 12 to 18 months after leaving care, such as violence, homelessness and sexual assault (Courtney et al, 2001). Unsurprisingly, with such poor outcomes, mental health and well-being are likely to be more compromised in care leavers as they struggle to attain self-sufficiency (Courtney et al, 2001). McMillen and Raghavan (2009) also indicated a substantial decline in the receipt of mental health services among approximately 400 young people leaving foster care. In a similar vein, Shook (2011) used data from a Birth Cohort of individuals in care, born between 1985 and 1995, finding that a very small number of those who left care continued to receive mental health services. The author suggests that the stigma of mental health and being in care discourages service use (Shook, 2011). However, when young people utilised services they failed to meet their expectations (Ridley & McCluskey, 2003). These studies demonstrate that vulnerability to mental health problems extends beyond pre-care and in-care experiences and that care leavers still require continued support. Assuring that after care youth have access to mental health services and receive general assistance will encourage a seamless transition from care to independence (Courtney et al, 2001).

In sum, sample sizes for care leavers have been relatively small, thus studies employing larger samples would provide more accurate results and conclusions. In addition, recruitment was mainly limited to specific cities, thus findings cannot be generalised nationally. Lastly most studies employed cross-sectional designs which prevent causal inferences, thus it cannot be concluded that leaving care caused

mental health difficulties. Research however has suggested that factors associated with leaving care (i.e. accommodation) can have a negative impact on mental health (Dixon, 2008; Duncalf, 2010).

2.7 Mental health training interventions for staff working with LAC & care leavers

Stein and Dumaret (2011) highlight the importance of early assessment and interventions aimed at care leavers. Mental health promotions and awareness campaigns have been developed in order to improve mental health literacy in the general population (Kitchener & Jorm, 2002). However, these are often community based interventions or primary care interventions. Targeted interventions for improving mental health literacy in local authority staff working with care leavers or LAC are rare. This is surprising, because ‘the overall picture we see is a children’s homes’ workforce trying to cope with difficult and complex tasks for which most have not been trained and for many of whom there are no plans to provide adequate training in the foreseeable future’ (Department of Health, 1992, p.116, cited in Hatfield et al, 1996, p.129). In addition Hatfield et al, (1996) found that although local authority staff came in contact with young people suffering from emotional and behavioural problems, few staff had relevant qualifications. A limitation of the study is that findings were purely descriptive, thus the study was preliminary in nature. It would be interesting to study the differences in the qualifications and experience of LAC staff and its relation to mental health literacy. More recent studies confirm the view that mental health literacy in LAC staff requires more improvement.

Focus groups with social workers have revealed that social workers are aware of their need for training, ‘almost all participants highlighted their training needs in understanding LAC mental health as well as

SDQ scores, particularly in relation to indicators of psychiatric disorder. It was suggested that such training would need to become part of the annual training programme' (Whyte & Campbell, 2008, p.201).

Sedgewick and Blackwell (2007) highlighted the need for a mental health training intervention to be developed and rolled out to Tier1 CAMHS employees. Tier1 workers were described as working with young people at some point in their job role, for instance; social workers, teachers and youth workers. One of the reasons put forward by Sedgewick and Blackwell (2007) was that The National Service Framework for Children's, Young People's and Maternity Services (Department of Health, 2004, cited in Sedgewick & Blackwell, 2007) stipulates that staff that work with children and youth need appropriate knowledge and training to facilitate the wellbeing of young people through early detection. Consequently, Sedgewick and Blackwell (2007) suggested that a CD-ROM training package would be useful for informing staff. A problem with e-learning may be that interaction with colleagues and coordinators may be reduced, thus such packages should be viewed as supplementary to more comprehensive staff training.

The importance of the role of social workers is well described by Aviram (2002, p.628) 'Social workers knowledge of social sciences is valuable in services where social factors are key to the occurrence and identification of illness, the course of illness, and seeking and getting treatment for mental illness...Their knowledge about community factors and skills of intervening in community settings can be an asset in an era in which individualising illnesses reigns'. Mount et al, (2004, p.365) argues that

‘carers (residential or foster) are relied upon to initiate the referral process. Their *intuitive judgement* of mental health need, which is based upon their knowledge of the young person, their understanding of mental health problems and potential risk factors, is paramount.’ This holds true for social workers and other youth workers, as Sedgewick and Blackwell (2007) argue that Tier1 workers have repeated contact with young people and are therefore strategically positioned for impact.

Despite this, when training and practices of mental health services were examined by Stiffman et al, (2000) they found that service providers from mental health and child welfare services had low rates of symptom recognition and poor accuracy when identifying young people with mental health problems and that service providers were a key determinant of service provision. What this suggests is that improving their identification of disorders through training is essential, to ensure service provision (McCrystal & McAloney, 2010). Overall Stiffman et al, (2000) concluded that in-service training should be available for anyone working with young people, because ‘in-service training enhances identification of youths’ problems’ (Stiffman, 2000, p.151). The authors note that the degree to which training influences behaviour needs to be explored.

A recent training by Cheng, et al, (2013) highlighted further benefits of training local authority staff including; mental health agency staff, youth workers and social workers. Results from a pre and post pilot evaluation of an early psychosis intervention programme developed in the UK demonstrated some improvement in knowledge three months after the training, but this was not significant. Although the intervention was developed in the UK the study was carried out in Hong Kong, thus cultural

differences are likely to influence findings and thus applicability to UK is limited. Additionally, baseline information about psychosis was attained retrospectively, thus accounts of first onset of psychosis may have been inaccurate. However, results showed that referrals to early psychosis intervention services were more likely to be approved after the training and six months post training focus groups revealed that participants benefited from the training and experienced better inter agency working.

The aforementioned studies confirm the need to train and utilise the expertise of youth workers. However, research in this area is sparse, further research on training LAC staff and improving their mental health literacy is needed.

2.8 Research limitations and conclusions

Methodological differences and individual differences between respondents and small samples sizes place a limitation on findings; small samples appear to highlight the difficulty in accessing this population. Additionally, secondary data and case files often relied on the accuracy of previous records and some research used self-report questionnaires, raising potential issues of social desirability, however qualitative studies yielded similar findings and themes and some studies enlisted the input of social workers and other relevant third parties. It is likely that the studies underestimated the prevalence of mental health difficulties in care leavers because the most disadvantaged young people dropped out or were not accessible. In addition, the terminology used to describe the care population is inconsistent, with studies using terms such as; foster care children, children in care, looked after children, residential

care, out of home care, group homes, care leavers, former relevant young people and foster care alumni. Thus a more standardised approach to terminology would simplify and unify research.

On balance, these studies provide a consistent picture emphasising the increased mental health needs of care leavers. Studies identified high prevalence of emotional difficulties, depression, isolation, risk behaviour, attempted suicide, lack of self-esteem and lack of family support in care leavers. We can see a striking paradox, in regard to mental health needs of care leavers where, despite the well documented increased mental health need in this population as described in this chapter, services are often withdrawn from this vulnerable group as they are leaving care. Post-care research has attributed this to inadequate preparation for leaving care, which can result in homelessness, poverty and severe mental health difficulties. Clearly the transition process is unsatisfactory and requires further development and improvements. Although Stein and Dixon (2006) noted that local authorities had good connections with housing organisations, this was not the case for mental health, as local authorities did not prioritise health (Stein & Dixon, 2006). Further evidence of this is that mental health training seems to be limited for local authority staff (Stiffman, et al, 2000). This is a concern because they play a pivotal role in working with young people who are susceptible to mental health difficulties (Sedgewick & Blackwell, 2007).

The majority of research focuses on the physical disadvantage of leaving care (housing and education) as opposed to emotional, psychological and mental disadvantage (Stein & Dixon, 2006; Dima & Skehill, 2011) and Dixon 2008 argued that research on the behavioural problems of young people leaving care is relatively sparse. Studies which do consider the mental health problems in the care population focus on LAC (in-care). This present study assesses the current level of mental health difficulties in care leavers focusing on; emotional and behavioural difficulties, depression, anxiety and

psychotic like symptoms. This will supplement evidence on the mental health and wellbeing of care leavers and provide directions for future mental health interventions aimed at supporting care leavers. An extension of this will include an evaluation of a pilot mental health training intervention aimed at improving mental health literacy in local authority staff.

3. MENTAL HEALTH OF SOCIALLY DISENGAGED YOUNG PEOPLE

3.1 Introduction

Office of National Statistics reports in the UK have suggested that upwards of 1 million young people aged from 16 to 24, were categorised as having NEET (Not in employment education or training) status in 2013 (Office for National statistics, 2013). The implications of this are potentially far reaching. This chapter provides a review of mental health and social disadvantage in socially disengaged young people that are not in employment education or training (NEET). The chapter provides a detailed review of the burdens and issues associated with social disengagement and particularly on the mental health and wellbeing associated with NEET status.

3.2 Young people not in employment education or training

A great deal of recent media and policy interest in the UK and other countries has suggested that NEET status is often associated with; ‘unemployment, poor skills, low incomes, poor housing, high crime, bad health and family breakdown’ -aspects of social exclusion (SEU, 2001, p.10). The Social Exclusion Unit (2001) suggest risk factors which can lead to social exclusion include; being in state care, family problems, educational difficulties, young offending, ethnic minorities, deprivation, mental health difficulties, age and disabilities and highlight the far-reaching effects that social exclusion has and how it can hinder social cohesion (SEU, 2001).

The rest of this chapter will summarise the research into aspects of NEET status and implications for individual mental health along with potential burden on health services and the state, particularly social capital in the UK.

3.2.1 The problem with being NEET: General overview

A plethora of research highlights the negative outcomes and general risk factors associated with social disengagement as; frequent periods of unemployment, low job security, low salary when working, early parenthood, young offending, homelessness, mental health difficulties, physical health problems, drug use, earlier death, deprivation, financial difficulties, low achievements, lack of support and stigma (Scottish Executive Social Research, 2005; Coles et al, 2010), all of which can be determinants of NEET status (Scottish Executive Social Research, 2005).

The Scottish Executive Social Research (2005) conducted a review of young people who are NEET. They identified the main NEET sub groups as; substance abusers, young offenders, care leavers, illness, family poverty/disadvantage and educational difficulties and disengagement. It is therefore unsurprising that Kieselbach (2003) found that socially disengaged youth were more likely to encounter poor self-esteem and poor mental health, in comparison to socially engaged youth, who had increased self-esteem and good communications skills. The study announced the importance of reducing hindrances to successful labour market involvement. However, they emphasised that social, financial and government support were protectors of social exclusion. This view overlooks internal protectors of unemployment such as; work ethic, locus of control, independence and desire to work.

A UK report by The Princes Trust (2014) documented that NEET young people were less happy compared to their counterparts who were in employment, education or training, with 40% of unemployed youth reporting mental health problems. Although findings were descriptive, they promoted the development of The Princes Trust Get Started programme, which supports long term unemployed young people (Princes Trust, 2014). Research that examines the effectiveness of such programmes would aid the development of interventions.

Several other studies have identified the negative impact of social disengagement. Atkinson and Hills (1997, cited in Bynner & Parsons, 2002) argued that the consequences of being NEET may include; dysfunctional relationships, limited social and political participation, poor physical and mental health, drug use and crime. Hammer, (1993) pointed out that crime and substance misuse were ways to which some young people coped. The authors do not suggest that unemployment leads to illegal activity, but that unemployment is associated with crime. Overall, studies are uniform in their findings that unemployment can arouse a cluster of social, psychological and financial problems. Clearly NEET young people require more support to avoid the possibility of employing maladaptive coping strategies.

3.2.2 Predictors of risk factors associated with NEET status

Bynner and Parsons (2002) used longitudinal data from the 1970 British Cohort Study, which involved 16,761 individuals born in Britain in 1970. Participants were surveyed at age 21 in order to examine predictors of NEET status. Results indicated that NEET status was predicted by parents not reading to a child and lack of parental interest in education, for girls aged 10 and boys aged 5. For boys living in

inner-city or impoverished neighbourhoods was a significant predictor of NEET status. A consequence of living in such deprived neighbourhoods is poor housing and schools. For girls, family poverty and a family without educational commitment or value were risk factors to becoming NEET and poor employment experiences were associated with NEET status in young men. For women NEET status was associated with poor psychological condition, such as, lack of control and dissatisfaction with life. It is important to note that the cohort's labour market experiences identified by Bynner and Parsons (2002) may not be relevant presently, as the labour market continues to change and unemployment is on the rise. In addition, the study mentions ConneXions as a UK government incentive to facilitate transitions into the workplace. However, this service is no longer in operation, suggesting that cutbacks have been made despite the rising unemployment figures. Nevertheless, social disengagement was predicted by poor labour market involvement, depression, early parenting and poor housing. While, Yates and Payne (2006) found that social disadvantage, educational dissatisfaction and underachievement were major contributors to becoming NEET. They also argued that the NEET term emphasizes negative traits and does not capture the heterogeneity of the group. In my view, the NEET category serves as a pointer for intervention; however the group can be dissected further to inform more targeted interventions.

When Pemberton (2008) conducted semi-structured interviews and a focus group with NEET young people and youth workers in Merseyside UK, findings indicated that; parental input, family breakdown negative educational experiences and lack of suitable opportunities contributed to NEET status. In addition, young people reported having difficulties meeting job requirements. The authors concluded that educational disaffection, family background, parental interest and level of aspirations all contributed to NEET status. In a more recent study Yates, et al, (2011) found that misaligned,

mismatched and uncertain aspirations were associated with the likelihood of becoming NEET for at least 6 months between 16 and 18 years of age. Misaligned aspirations had a more damaging effect on 52% of those with low socioeconomic status compared to 28% in peers from high socioeconomic backgrounds.

It has been suggested that the multitude of risk factors associated with NEET status can hinder the ability to accumulate personal, social and human capital. These concepts are described and examined by Caspi et al, (1998); they investigated the unemployment outcomes of young people transitioning into adulthood. A longitudinal study was conducted with a birth cohort of young adults and variables included; human capital, social capital and personal capital. Human capital involved 'resources, qualifications, skills and knowledge available to and acquired by individuals to maximize their own employability' (Caspi, et al, 1998, p.427). Social capital referred to social networks or relationships and personal capital included general wellbeing 'behavioural characteristics and resources that affect motivation and capacity to work' (Caspi, et al, 1998, p.428). Human capital was ascertained by; level of qualifications, reading ability, parental resources, and IQ scores. For social capital, upbringing, single parent family, family conflicts, and connectedness to school were assessed. Finally, antisocial behaviour and increased risk of unemployment was associated with low personal capital. Results showed that all variables were significant predictors of future unemployment. Adolescents with parents employed in low status jobs were more likely to become unemployed, compared to high status families and adolescents without school qualifications were more likely to become unemployed compared to those with qualifications. Those with low reading scores had a higher probability of becoming unemployed (23%) compared to those with high reading scores. They concluded that human, social and personal capital all contribute to predicating future unemployment. However, personal and social

capital appeared to be stronger in influencing employment outcomes. This study provides more evidence that a multitude of factors are present in determining employment outcomes of young people. The use of a longitudinal design averted some of the limitations associated with cross-sectional designs. Thus results demonstrated that unemployment in adulthood could be predicted from early childhood and family background. The authors noted that more investigation on the causes and constructs of unemployment should be explored. However, the study succeeds in highlighting that interventions in early life could be an effective strategy.

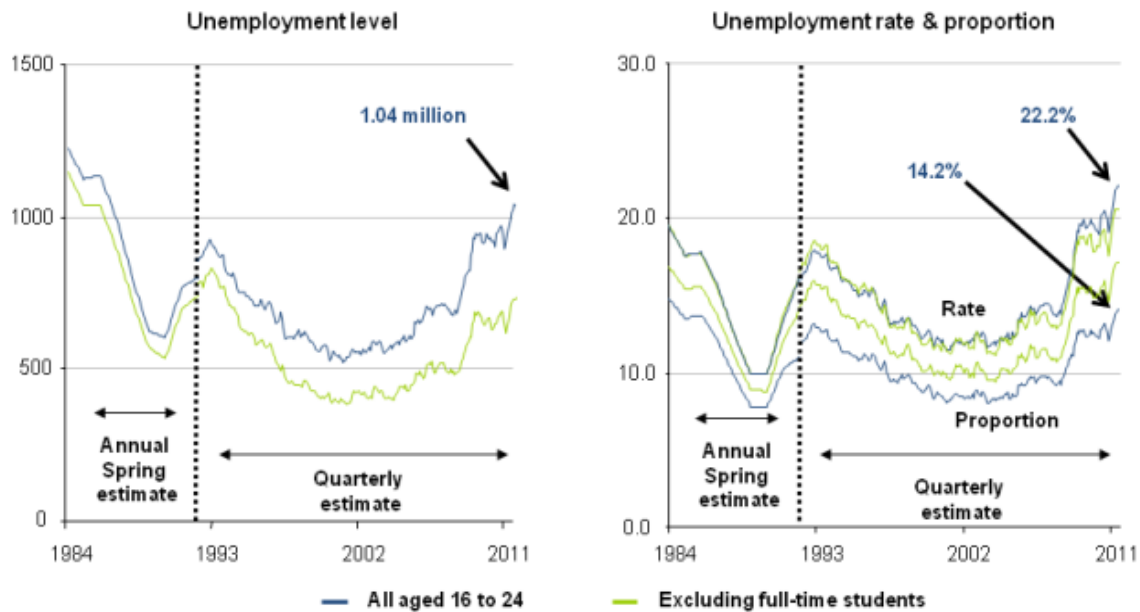
In all, research and policy has outlined factors associated with non participation in employment and education. The most persistent risk factors associated with NEET status included; unemployed household, not participating in education or training, smoking, lack of internet access, not owning a home and early parenthood (SEU, 1999; Cusworth, 2009). It has been concluded that the ‘most significant triggers of multiple disadvantage in young adulthood is having lived in a family who was in receipt of income support, this stresses the need to break the intergenerational cycle of deprivation’ (Cusworth, 2009, p.36).

From the aforementioned studies it can be concluded that the NEET population is not a homogeneous group (Furlong, 2006; Nudzor, 2010) and they have a multitude of underlying difficulties that bring about their NEET status (Bynner & Parsons, 2002).

3.2.3 The Number of NEET young people

Those with NEET status encapsulate people with a wide variety of needs; this puts a strain on individuals and on the economy. The Social Exclusion Unit (1999) argued that being NEET places more pressure and burden on health services, social services, youth justice services and other resources. The Office of National Statistics (ONS, 2011) estimated that there are 730,000 unemployed young people ages 16 to 24. However, they noted that three months to September 2011 unemployment rates had increased by 58,000 compared to the previous quarter. Estimates of youth unemployment have continued to increase, with the ONS, Characteristics of Young Unemployed People (2012, p.1) stating that 'Unemployment for young people in the UK aged 16 to 24 in October to December 2011 stood at 1.04 million, the highest number since 1986/87' (Figure 3.1). Although 30% of young people were in full time education or actively seeking employment, these figures are staggering.

Figure 3.1 Unemployment rates 1984 to 2011 for young people age 16 to 24.



Source: Labour Force Survey - Office for National Statistics, cited in ONS, Characteristics of Young Unemployed People (2012, p.2).

These figures highlight the increasing difficulties young people face transitioning from school to further education or the work place. Reports have shown a consistent growth in the estimation of youth unemployment. However, reasons for unemployment are not detailed, thus the contexts of unemployment should be applied when interpreting these estimates.

Explanations for increased unemployment figures are outlined by Bell & Blanchflower (2010) who argued that the majority of youth unemployment in UK occurs between ages 18 to 24 and there has been a 74% decline in the employment of young people within this age range. Another explanation was

put forward by Coles et al, (2010). They estimated the life time costs of young people who are NEET finding that the amount of youth in education, employment and training has increased; however, the amount of youth within the NEET group is also on the rise. A reason for this is that the percentage of NEET populations has increased due to the recent recession and changes in the labour market, with students now taking part time jobs which 16 to 18 year old school leavers may have previously occupied (Coles, et al, 2010; Bell & Blanchflower, 2010).

3.3.1 Cost of being NEET

Other reports have estimated the financial burden NEET status has on the economy, for instance, McNally and Telhaj (2007) reported that one in five young people in England, Scotland and Wales were NEET and that the loss of economic productivity costs 70 million per week, with the cost of job seekers allowance alone reaching 20 million per week. On balance, McNally and Telhaj (2007) reported that youth unemployment costs £4.8 billion a year. These figures illustrate the striking impact youth social disengagement has on the economy. Coles et al, (2010) estimated the life-time cost of educational underachievement, unemployment and economic inactivity to be at an all time high. Costs included Job seekers allowance, housing benefits, tax losses, educational underachievement, crime, substance misuse, health and early parenthood. Resource costs were estimated between 21 billion and 76 billion pounds and public finance costs were estimated between 11 billion and 32 billion pounds. They argued that broken employment or unemployment affect pensions and subsequently increase the strain and dependence on public resources later in life. Thus, NEET status is not limited to increased current and long term public spending, but snowballs into lifetime costs beyond retirement (Coles, et al,

2010). They arrived at the conclusion that young people at risk of ‘labour market disengagement’ need support in order to curb public spending now and in the future (Coles, et al, 2010, p.49). The study produces an economic perspective on the NEET problem and highlights the scale of the issue. In recent times wages, tax and prices have changed, thus these estimates may no longer be accurate. The study does however provide information on the alarming effects unemployment can have on public spending.

In response to the NEET problem educational incentives have been developed in the UK, however, the value of such interventions have been queried by Maguire and Rennison (2005), they found that a UK government scheme targeted at NEET youth was ineffective if young people were already NEET, because reengaging them into education or employment may be ineffective if underlining issues persist.

3.3 Mental health and wellbeing difficulties associated with NEET status

Another serious issue associated with disengaged populations is their mental health, earlier studies by Warr et al, (1988) and Lakey et al, (2001) concluded that in Britain, unemployment led to high levels of depression, anxiety, distress, low self-esteem and lack of confidence and perpetual unemployment was associated with poorer wellbeing and mental health compared to controls. According to Bynner and Parsons (2002) there appears to be an association between disengaging from work or education and having worse psychological states, such as, lack of control over life and being discontent with life. Such disengagement frequently results in poverty and financial anxiety which has been found to have a negative influence on psychological health and wellbeing (Bynner & Parsons, 2002).

A more recent study coincides with the finding that socially disengaged youth experience serious psychological difficulties, Benjet et al, (2012) estimated the incidence of mental health disorders, substance abuse and suicidal behaviour in NEET young people living in Mexico City. Results showed that NEETs had a greater likelihood of reporting mood disorder (13.3%), anxiety disorder (34.3%), behavioural disorder (13.5%) and other serious disorders compared to those in full time education. NEETs were more likely to attempt suicide or experience suicidal ideation compared to students and those in employment. In sum, NEETs had greater psychiatric disorders even after controlling for social disadvantage, while those in education fared best. A limitation of the study is that inferences on causation and directionality could not be made and the authors described the Mexican youth labour market as exploitative. Thus findings in Mexico may paint a bleaker picture of unemployment compared to the UK. Nevertheless, Benjet et al, 2012 concluded that 'Disengagement from socializing institutions (education and work) may be a reflection of prior mental disturbance or may increase the risk of psychopathology either by failing to provide structure and the necessary developmental experiences or by increasing exposure to other disenfranchised or non-normative peers' (Benjet, et al, 2012 p.415).

Evidence from the Civil and Social Justice Surveys (cited in Sefton, 2010) revealed that social welfare issues with employment, housing, finances & benefits increased reported mental health problems; 31% of those who reported social welfare problems also reported increased mental health difficulties, compared to 9% for those who did not report social welfare problems and those reporting increased social welfare problems were NEET or homeless (Sefton, 2010). Findings indicated that NEET young people had an increased likelihood of experiencing mental health difficulties compared to those in education, employment or training. Overall, 32% of 18 to 24 year olds that were NEET reported mental

health difficulties, 12% reported long term difficulties and 16% reached the threshold for possible psychiatric disorder, compared to 11% of non NEET groups. Negative consequences such as stress, lack of confidence and worry were reported more frequently in NEET young people.

On a more positive note, data from The British Household Survey (cited in Thomas et al, 2005) explored the transition between types of employment and their effect on psychological wellbeing. Results revealed that transitioning from unemployment to employment was associated with improved mental health. Prevalence of psychological distress was 35.5% for the unemployed, this decreased to 28.2% when re-employed. Psychological distress during employment was 32% and it increased to 35.5% when transitioning to unemployment. Similarity, Hammer (1993) found that mental health difficulties were greater during unemployment and symptoms were reduced during sustained employment.

The aforementioned studies provide a foundation which links unemployment or social disengagement to poor mental health. However, more recent work regarding NEET young people and mental health difficulties is required in the UK context.

3.3.1 Social isolation and mental health difficulties

Additionally, stigma and social isolation can have a negative impact on mental health, as reduced social activity often results in less social support (Bartley, 1994). The UK AESOP study conducted by Reininghaus et al, (2008) investigated how social isolation influences unemployment, risk of psychosis

and duration of untreated psychosis. Patients with first episode psychosis were screened using the screening schedule for psychosis in; London, Nottingham and Bristol. Findings suggested that the probability of screening positive for psychosis was increased when participants reported less time spent with family, friends and others during the week. The more socially isolated unemployed participants were, the higher the likelihood of them being a case. Plus, unemployed participants who had low to medium contacts had longer periods of psychosis than those with higher social contacts. They also found that if achievements did not match expectations participants were more likely to screen positive. In conclusion the relationship between psychosis and unemployment was stronger in those who were socially disengaged. A limitation of this study is that although the frequency of social contacts was measured, the quality and satisfaction of social contacts was not and it was not made clear if social isolation was before the onset of psychosis or as a result of the onset of psychosis. Nonetheless, findings are indicative of the potential power of social contacts in minimizing adverse effects of even serious mental health conditions.

Hammer (2000) surveyed 8000 young people in five Nordic countries 6 to 12 months after being registered unemployed. They found an association between mental health difficulties, poor income and social isolation. Poor income was strongly associated with mental health difficulties and social isolation was found to increase mental health symptoms in some countries. For countries with less unemployment such as Norway, such associations were not found. It should be noted that the study utilised a 10 item scale focused on depression and anxiety. Thus, a more elaborative measure encompassing emotional and behavioural difficulties may have expanded their conclusions. Their point was however, that unemployment can be a catalyst for poor mental health outcomes. In agreement with these findings, Bromme et al, (2005) and Aiello et al, (2012) argued that social adversity such as social

isolation and increased sensitivity to stress are risk factors of psychosis. However, the mechanisms involved in the transition to psychosis are not fully understood and more research is required in this area. Here the core argument appeared to centre on social isolation, anxiety, and mismatched expectations as risk factors for developing serious mental health difficulties, what is evident is that these risk factors are predominantly found in NEET populations. Essentially, those that were not in paid employment encountered greater social loneliness (Creed & Reynolds, 2001) thereby increasing the likelihood of developing mental health problems (Reininghaus et al, 2008).

3.3.2 Young offenders and mental health

A prominent feature in the NEET category is young offending. The Social Exclusion Unit, (1999, p.58) noted that ‘offending and non-participation are strongly associated’. Phillips and Brown (1998) Found that 75% of NEET young people were charged with a criminal offence and they found strong evidence that unemployment was prevalent in those involved with the criminal justice system.

As young offenders constitute a part of the NEET category, it is worth mentioning that this subgroup often faces enormous mental health difficulties, as pointed out by Teplin et al, (2002), they found that over half of male and three quarters of female youth in prison had one or more psychiatric disorders. In another study 44 young offenders between 10 and 18 years of age completed self-report questionnaires on mental health, six agreed to do follow-up interviews. Measures included the Strengths and Difficulties Questionnaire, which was administered over one time period, thus causality was not established. A longitudinal approach would have provided more information about the link between

incarceration and mental health difficulties. Additionally, Hispanics were overrepresented in US criminal justice institutions (Teplin et al, 2002), thus the comparability to the UK is limited. Results however, indicated that young offenders had a high level of mental health disorders, particularly for conduct disorder, hyperactivity, emotional disorder and peer problems; however, pro-social scores did not differ from normal scores. In addition, they found that young people engaged in more informal help seeking due to barriers to accessing professional health services, i.e. social and cultural barriers (Walsh, et al, 2011). Young offenders have been well recognized as having elevated difficulties with; mental health, education, employment, social skills, substance abuse and IQ; however, they do not always receive appropriate support (Bailey, 2003 & Chitsabesan, et al, 2006; Casswell et al, 2012).

A current observational study carried out in Italy by Nardi et al, (2013) examined 143 young people age 16 to 19 who had criminal justice involvement and were not in employment education or training. Data was collected from social folders including notes from psychologists and social assistants. Results indicated that 18.9% of the sample was already diagnosed as having psychiatric disorders and a staggering 81% of NEET young people had mental health disorders compared to 18.5% of non NEETs. Interestingly, antisocial behaviour was highly prevalent in 40.7% of the group, cognitive impairment was prevalent in 29.7% and mood disorders was found in 22.2% of the sample. With observation they found that NEET young people had low satisfaction with friendships, this was greater in girls. The study mainly consisted of male participants, thus gender bias may have occurred. In addition, the non NEET control group were derived from the same criminal database as the NEET young offenders group. Thus, comparisons with NEET young people without criminal justice involvement would provide further clarity on the relationship between young offending and mental health difficulties.

The authors argued that the secluded nature of NEET young people with criminal justice involvement was due to lack of social cohesion or acceptance, which may result in social loneliness and subsequent mental health problems (Creed & Reynolds, 2001; Reininghaus, et al, 2008).

3.4 The psychological impact of youth unemployment

As mentioned previously, studies suggest that those who are unemployed experience social isolation and greater mental health difficulties. Banks and Jackson (1982) investigated the relationship between unemployment and psychiatric morbidity in 16 year old school leavers and identified a strong association between unemployment and increased symptoms on The General Health Questionnaire (GHQ, cited in Banks & Jackson, 1982). Due to the longitudinal design of the study, the authors concluded that unemployment resulted in increased symptoms on the GHQ. Although the study was restricted to 16 year olds who may just be entering the labour market, it provided a foundation for youth unemployment research. Following on from this, Murphy and Athanasou (1999) argued that unemployment is a significant cause of psychological disturbance. They reported an effect size of .36 ($k=5$) for mental health changes due to unemployment and the effect size increased to .54 ($k=7$) when those who were unemployed became employed, indicating better mental health when re-employed. What these findings imply is that the negative impact of unemployment on mental health is smaller than the positive impact re-employment has on mental health. Suggesting that interventions focused on re-employment may have a more positive impact. A limitation of the study is that there were limited adjustments made for confounds, thus results may have been influenced by unknown variables. However, findings were confirmed by Paul and Moser (2009), who conducted a more recent meta-

analytic study to integrate findings regarding unemployment and mental health. Studies have shown a negative effect between joblessness and mental health, with rates of potentially severe psychological difficulties ranging from 16% to 34% (Paul & Moser, 2009). Those who were unemployed were significantly more distressed compared to employed counterparts; for depression the effect size was ($d=0.51$), anxiety ($d=0.40$), wellbeing ($d=0.51$) and self-esteem ($d=0.45$), these were significant and moderate effects (Paul & Moser, 2009). Although the meta-analysis included a small number of studies the authors concluded that ‘unemployment is a serious threat to mental health’ (Paul & Moser, 2009, p.280). They also found that re-employment improved mental health (Paul & Moser, 2009), confirming previous findings.

Hagquist (1998) identified an association between economic deprivation and suicide in young people. This is buttressed by Morrell et al, (1998) who found that 11% of psychological distress in unemployed Australian youth was accounted for by economic deprivation. While, experiential deprivation (social contact, structure) accounted for 23% of psychological distress and was predicated by social loneliness. Morrell et al, (1998) concluded that those working full time had the least psychological difficulties, while those who were unemployed reported greater psychological distress. While it is likely that Australian unemployment data differs from the UK, the findings match other studies.

Despite the aforementioned issues, studies point to the conclusion that youth employment is better for mental health and wellbeing. Thus focus should be on engaging young people into the labour market and understanding mental health difficulties in this group.

3.4.1 Work ethic in young people

An international study in Japan was conducted by Genda (2007) who identified three different types of unemployment categories.

1. Job seeker (actively seeking employment)
2. Non job seekers (inactive but want to work)
3. Non job seekers (No desire to work)

Genda (2007) argued that, educational attainment was a factor in joblessness. Highly educated individuals were often active job seekers, while those with low educational attainment, were inactive jobseekers or did not want to work. In this case it appears that high educational attainment was a buffer against the negative effects of unemployment, perhaps due to higher identity capital (Bynner & Parsons, 2002). In addition, they found that 20% of single parents had no desire to work. It was concluded that ‘jobless youth are not jobless simply because of lack of work but because of social class or family structure...young people in Japan from disadvantaged social backgrounds...from underprivileged classes may be more likely to be discouraged from working ’ Genda (2007, p.39). Reasons as to why this is the case require further explanation, for instance; why social disadvantage leads to less desire to work instead of increasing motivation to work. Despite the study being within a Japanese context, the findings offer potential factors that can lead to joblessness. An earlier study conducted in the Netherlands by Schaufeli (1997) also found that young people who were better educated had better coping strategies and a better psychological response to unemployment. The author suggested that increased social status augments self-esteem and in turn, high self-esteem compensates for the negative effects of unemployment. Well educated young people were described as proactive

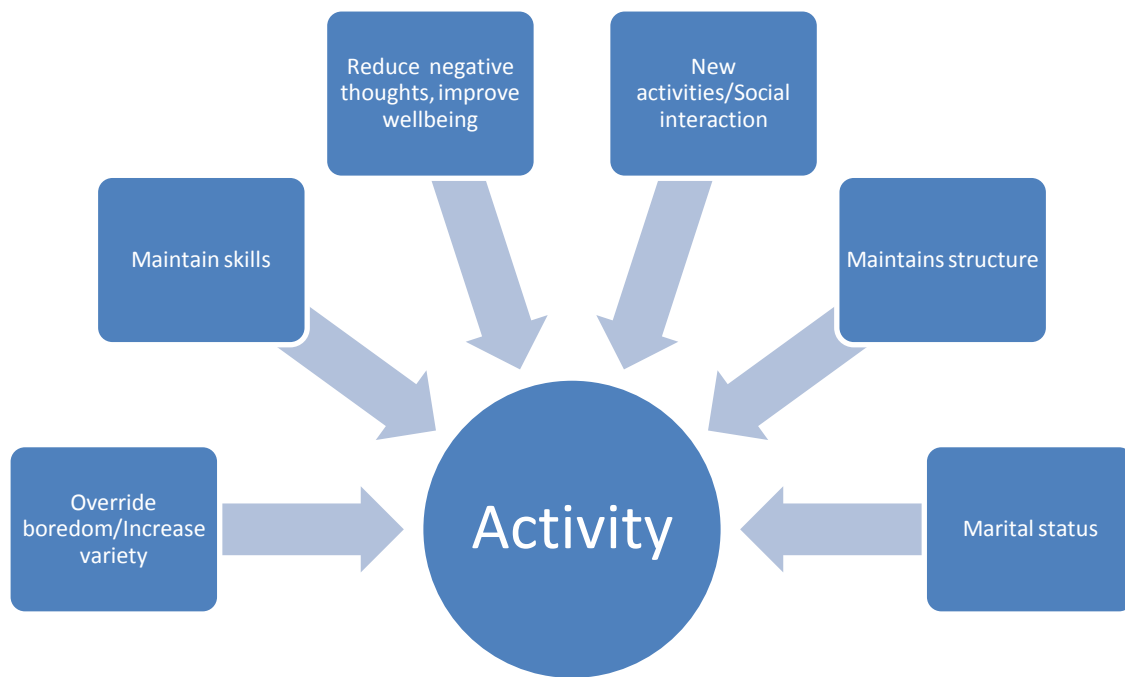
during periods of unemployment, 40% of unemployed well educated young people were engaged in unpaid activities, thus unemployed well-educated youth were not 'passive victims' and were able to seek alternatives during periods of unemployment (Schaufeli, 1997, p.265).

In contrast, other studies describe young people as willing to work rather than passive, but their willingness is often met with poor quality employment. Chen (2011) conducted interviews with young people in Taiwan who were NEET. Interviews revealed that young people wanted to work and be financially independent and that those who wanted to further their education could not meet the demands. These sentiments were echoed by Simmons and Thompson (2011) who examined education and employment schemes in UK and found that young people reported negative educational experiences such as, no longer attending school, truanting or being excluded. Despite these experiences young people still expressed a desire to enter employment or further their education (Simmons & Thompson, 2011). In parallel, MacDonald (2008) established that young people did participate, however the options and opportunities available to them were poor. MacDonald (2008, p.1) stated that young people experience 'economical marginalization' because their enthusiasm is often met with a lack of quality and valuable opportunities. In addition, Finlay et al, (2010) explored the experiences and aspirations of young people in Scotland, using case studies, activities and discussions. They found that young people had low expectations not aspirations. A limitation of their qualitative approach was that a 'participant led' approach was used instead of semi-structured interviews (Finlay et al, 2010, p, 857), thus findings were more ambiguous. However, the study did suggest that an intervention which raises expectations that young people have about their future is likely to be effective. Plus, interventions working with employers to create more job opportunities should be increased.

These studies move the spotlight towards creating suitable opportunities for young people to join the labour force. It may be that young people's expectations need to be adjusted and more realistic. Thus young people need more information and guidance regarding education and training to properly position themselves for suitable employment.

In accordance with the aforementioned studies, Underlid (1996) argued that any purposeful activity during periods of unemployment can override negative thoughts and feelings in young Norwegians. Underlid (1996) conducted structured interviews with people who were registered as unemployed. It was found that high activity during unemployment and involvement in purposeful activities increased self-esteem and facilitated mental skills. Underlid (1996) went further and listed the stress buffering effects of increased activity during periods of unemployment (Figure 3.2). This view is reiterated in a review by Mclean et al, (2005, p.15), they argue that the ability to 'fill a day' is associated with better wellbeing during unemployment and increased variety during the day was associated with decreased levels of depression and anxiety. In a similar vein, Rothon et al, (2012, p.707), reported that those involved in non directed social activity or 'hanging about' were more likely to be a case on the GHQ (Rothon, et al, 2012, p.699). This implies that social aloofness can increase the propensity to develop mental health difficulties. It is therefore important that such young people are positively engaged and do not become marginalised.

Figure 3.2 Benefits of meaningful activity during unemployment (Underlid, 1996: Dooley, et al, 2000; Mclean, et al, 2005)



Underlid (1996) noted that results cannot be generalised due to socioeconomic differences and varying opportunities between countries. Still, increasing evidence supports the position that unemployment can have a negative impact on mental health because of social inactivity or disengagement. Sellstrom et al, (2011) concurs with this view, they examined the level of mental health in inactive young people aged 20 to 24. Young people were followed up every year, and information was collected about depression, alcohol abuse, drug abuse and self harm. Economic activity was ascertained based on receiving a registered income and student subsidies as opposed to those on leave or those not registered as employed. Findings showed that young adults who were economically inactive had a higher risk of

developing serious mental health problems compared with those who were participating in employment or education. Economically inactive young people were more likely to be admitted into hospital for substance abuse, depression and self-harm (Sellstrom, et al, 2011). The authors demonstrated that mental health deteriorates during periods of economic inactivity; on the other hand, those with mental health difficulties were less likely to be economically active.

Research has been consistent in finding that unemployment and social or economic inactivity can lead to negative mental health outcomes. Fergusson and Horwood, (2001) carried out a review of epidemiological findings on the association between unemployment in adolescence and risk of maladjustment. Results indicated that those exposed to at least six months of unemployment had increased rates of mental health difficulties, crime, substance misuse and suicidal tendencies compared to employed peers. They argued that unemployment was significantly associated with thoughts of suicide, substance abuse and young offending.

These studies emphasise the importance of positive activity during periods of unemployment, however it can be argued that those with better wellbeing engage in more positive activity or those with increased resources can engage in more social activities (i.e. gym, travel, hobbies). Thus, further research is needed to understand the causal influences on activity levels during periods of unemployment, in order to encourage purposeful activity in unemployed young people.

3.4.2 Employment type and mental health and wellbeing

Generally, studies have recognized that employment plays a pivotal role in mental health; more specifically working patterns can have an effect on psychological health. According to Creed and Reynolds (2001) the amount of labour market engagement is what determines wellbeing. They investigated a range of psychological outcomes in 148 young people as a result of occupational experiences and young people were separated into four groups; unemployed with no form of income, unemployed with some form of income, unemployed with regular income and those in full time employment. Psychological difficulties were measured using The General Health Questionnaire-12 (cited in Creed & Reynolds, 2001). Results indicated that those in full time employment had better wellbeing, while those with the least engagement with the workforce had greater psychological distress. Having regular paid work offered similar benefits to full time employment and those who were unemployed experienced worse mental health and wellbeing outcomes (Flatau, et al, 2000; Creed & Reynolds, 2001). The authors noted that longitudinal studies would be required to ascertain the role of causality (Creed & Reynolds, 2001).

Similarly, Dooley et al, (2000) conducted a study using interviews by the National Longitudinal Survey of Youth. Findings from a correlation analysis indicated that those who were unemployed or in inadequate employment (part time involuntary jobs & low wage) were significantly more depressed, compared with those who were fully employed. They found that depression was increased in females, the less educated, those with low self-esteem, those with children and those who did not have job satisfaction. Furthermore, those who were single fared worse than those who were married. Marital

status seemed to buffer the effects of stress associated with employment status. This reinforces the importance of social support compared with social isolation. The study did suggest that unemployment and inadequate employment predicted a significant increase in depression for young adults. Sustained major depression on more than one occasion was associated with becoming unemployed six months later. Put in another way, unemployment could lead to major depression, which in turn may perpetuate sustained unemployment. A review conducted by Lorant et al, (2003) showed that low socioeconomic status faintly increases the risk of depression and moderately increases the risk of developing persistent depression. It is interesting to note that coping style, self-esteem, mastery and locus of control were also found to protect against the adverse effects of stress.

Taken together, these studies clearly indicate the negative impact unemployment has on young people. However, Winefield (1991) found that unsatisfactory jobs could be as depressing as unemployment. This raises some implications, with regards to re-engaging young people into the labour market. Yates et al, (2011) argued that there is a 'lack of traditional, valued and secure jobs for lower achievers' (Yates, et al, 2011, p.532). It is likely that the jobs on offer after a bout of unemployment may not be ideal and young people may find it hard to climb the career ladder (Yates et al, 2011). However, many of these studies use correlational designs, thus it is difficult to demonstrate causality. Nonetheless, these studies illustrate the effect job type and socio economic status has on mental health and wellbeing.

3.4.3 Theories of unemployment

Research has been consistent in their portrayal of the negative effects of unemployment and social disengagement. Other studies mentioned below have proposed theoretical approaches to explain the negative outcomes associated with social disengagement, in this case unemployment.

Jahoda (1981) developed the latent deprivation model, which argues that distress during unemployment can be attributed to the absence of latent functions. These functions are summarised by Paul and Batinic (2010, p.45) as; ‘time structure, social contact, collective purpose, and activity’. Johoda (1981) argued that these functions are important psychological needs which can only be provided sufficiently by employment and that employment fills people’s day in a constructive manner, provides regular social contact, common goals and purpose. These functions have been found to have a positive effect on mental health. Thus a consequence of unemployment is being deprived of these latent functions, suggesting that unemployment can be ‘psychologically destructive’ Johoda (1981, p.188). What is worrying is that these functions appear to be more accessible to young men from a high social status (Paul & Batinic, 2010). When opportunities to build social capital are limited or inaccessible this can result in poor life outcomes (Caspi, et al, 1998). Thus, interventions that focus on providing these functions in unconventional settings may help engage vulnerable young people.

Johoda’s Model set the scene for future theories, such as Warr et al, (1988) who proposed a vitamin theory. The vitamin theory which describes nine benefits of work as vitamins; some workplaces have low or high doses of vitamins. If one is deficient in receiving these vitamins or has them in excess,

Warr et al, (1988) argued that it may result in depression, anxiety and reduced wellbeing. The vitamins included;

1. Opportunity for control
2. Opportunity for utilizing skills
3. Externally generated goals
4. Variety
5. Environmental clarity (uncertainty)
6. Availability of money
7. Security
8. Interpersonal contact
9. Social status or position

The vitamin theory differs from Jahoda in that the vitamins are applicable to jobs, unemployment and any environment, whereas, Jahoda's theory puts a clear demarcation between employment and unemployment. Their point is however, that the absence of these vitamins or functions can result in a decline in psychological health. Overall NEET groups appear to lack such vitamins and latent functions, which puts them at increased risk of mental health difficulties (Jahoda, 1981; Warr, et al, 1988). This is refuted by Ezzy (1993) who argued that Jahoda's model is too objective and paints a rosy picture of the work place. Rather, Ezzy (1993) suggests that the interpretation and meaning of work to an individual influences mental health and wellbeing, thus favouring a more subjective approach. This complements research by Bynner and Parsons, (2002) who found that past experience of work had an effect on psychological wellbeing. Another limitation of Jahoda's theory is that there is no cut off point or clear distinction between abnormal or normal amounts of functions. For instance,

how many functions are needed to prevent lack or deprivation or should all functions be fulfilled to experience the benefits of work. Furthermore, the emphasis on latent functions overshadows the obvious benefits of work, such as getting paid. In addition, the importance of each function may vary from person to person, thus benefits of work may not be generalisable. Lastly, the functions seem to act as mediators between employment and mental health, thus further research on these functions may help the identification of causal mechanisms.

However, in agreement with Jahoda's model an Australian study by Waters and Moore (2002) found that unemployed individuals engaged in more solitary activities and less frequent social activities compared to those in employment. Those that were unemployed also reported increased depressive symptoms and low self-esteem. Furthermore, they reported a lack of time structure, socializing, personal identity, collective purpose and enforced activity. Those who were employed did experience some latent deprivation however, this had a weak impact on psychological wellbeing compared to those experiencing unemployment. They found that loss of personal identity, lack of social contact and experience are strong contributors to latent deprivation. In essence, Water and Moore (2002) suggested that involvement in meaningful activities during unemployment mitigate the negative effects and serve as a valuable coping strategy.

3.5 Impact of not being in education for young people

Despite the varying methods in previous research, results consistently indicate that the prevalence of common mental difficulties were higher in those with low educational attainment, unemployment and low income. Overall, low educational attainment was the strongest predictor of social disadvantage (Fryers et al, 2003). Bynner and Parsons (2002) suggest that there are many underlying factors that need to be addressed to tackle the NEET problem and at the forefront appears to be education, as ‘the experience of being NEET simply compounds a history of educational failure, reducing prospects of employment or for acquiring human capital through education and training’ (Bynner & Parsons, 2002, p.302), this is echoed by The Social Exclusion Unit (1999), which states that pathways for young people who underachieved in education were unclear, as a result, these young people experience no subsequent ‘education or training, but some combination of short-term, poor quality jobs with no training, a lack of any purposeful activity and, all too often, a descent into the hardest end of the social exclusion spectrum – a variety of relationship, family and health problems, including homelessness, persistent offending or problem drug use’ (SEU, 1999, p.8).

In a similar vein, Koivusilta et al, (2006) examined the effects of family affluence (possessions), adolescent’s academic performance, family occupation and education on health differences. Overall results showed inequality in health based on socioeconomic differences. Adolescents from higher social positions reported better health compared to those from low social positions. Low status for the father was associated with poor self-reported health in adolescents, being overweight and using mental health services. A significant association was found for adolescent’s academic achievement and health.

Poor educational achievement was associated with worse mental health. This agrees with findings from a US study, which states that ‘the poorer ones socioeconomic conditions are, the higher ones risk of mental disability and psychiatric hospitalization’ Hudson (2005, p.16). This view is elaborated by Magklara et al, (2010) who conducted a cross sectional survey in Greece with 5614 adolescents aged 16 to 18. The study aimed to investigate sociodemographic inequalities and general and psychological wellbeing. They used a simple self-report questionnaire for the initial stages of the study and sociodemographic variables included; parent’s education, parent’s employment status, financial status, adolescents position i.e. academic performance and other variables. Although the measures for general and psychological health were few, results showed that one in three adolescents lacked good psychological health, with older adolescents reporting poorer general and psychological health. The authors concluded that family status and personal academic performance indicated psychological health. It could be argued that these studies overly focus on material wealth, but neglect other types of wealth such as; loving family environment, time spent with family and quality of relationships. Using family support as markers of affluence should also be considered rather than physical markers alone (i.e. number of cars in a household).

The link between social relationships, connection to school and mental health and wellbeing in school pupils was established by Bond et al, (2007). A longitudinal design was employed and pupils were assessed at 13 to 14 years, 16 years and a year after leaving school. Correlation analysis revealed that young people had a higher probability of having mental health difficulties in the future if they reported low school engagement and interpersonal problems. Increased school and social engagement was associated with decreased depressive symptoms; low school engagement with increased social

engagement was associated with; increased drinking, anxiety, depression and smoking marijuana. This would suggest that increasing school and social connectedness would have a greater impact on outcomes. In addition, Rothon et al, (2012) found that social support, parental involvement and increased social activity were linked with improved mental health and education in young people. The problem is that once young people are socially disengaged reconnecting them back to education or employment becomes difficult (Maguire & Thompson, 2007), this is for a variety of reasons, which are pointed out by MacDonald (2008), who conducted qualitative research based on 185 young people ages 15 to 25 growing up in Britain's poorest neighbourhoods. Findings indicated that participants left school with poor qualifications and low level, low value training, which was often uncompleted. MacDonald (2008) suggested that this may be due to young people's resistance and rejection of formal education combined with the systems inability to engage them. Post school experiences were often characterized by unemployment, lack of stability, inconsistency, and poor progression (MacDonald, 2008).

What these studies highlight is that economic and social inequalities can play a destructive part in society if not addressed. However, current policy papers questioned the 'capacity of any form of re-engagement to overcome the social and educational divisions that are already deeply entrenched by the time we come to be concerned about their engagement in post-compulsory education or the labour market' (Simmons & Thomson, 2013, p.9). Essentially, research suggests that those who are disengaged, disconnected or have underachieved in education are more likely to constitute a high risk group, in terms of risk of mental health problems. It has been suggested by Sznitman et al, (2011) that positive wellbeing may compensate for socioeconomic adversity, they studied the role of emotional

wellbeing on poverty and educational attainment in 13 to 18 year olds. Finding that emotional wellbeing in adolescents was a mediator for poverty and educational attainment. Although the study focused on internalised disorders such as depression, thereby overlooking behavioural problems, findings suggest that by improving emotional wellbeing, young people may be able to reconcile the differences between poverty and educational underachievement (Sznitman, et al, 2011). If this is the case, research should focus on the emotional wellbeing of more disadvantaged populations, rather than solely on educational and employment outcomes.

3.6 Long-term effects of social disengagement

The 1970 British Birth Cohort study, cited in Executive (2005) revealed that being NEET for six months increased the probability of; long term unemployment, depression, other mental health issues, having a criminal record and having fewer qualifications, in males by the age of 21.

In connection with this, The Social Exclusion Unit, (1999), found that non participation in education employment or training at 16 to 18 years of age predicted that by age 21 young people were more likely to lack qualifications, training and be unemployed and earnings were less compared to those who had not been NEET. They also found that by 21 the NEET young people were more likely to have children and experience mental health and physical health problems. This concurs with Jefferis et al, (2011), they reported that being unemployed was consistently associated with an increased risk of depressive symptoms and major depression six months later.

Another study by Hammarstrom and Janlert (2002) aimed to identify the effects of early unemployment in later adulthood emphasising the negative long term effects of social disengagement at a young age. They conducted a 14 year longitudinal study in Sweden with school leavers aged 16. Questionnaires were used to measure somatic symptoms and psychological symptoms and included subscales on depression and nervousness. Firstly, participants were grouped by duration of unemployment and age. Findings demonstrated that unemployment at a young age had long-term negative health effects in adulthood for both men and women, with the unemployment group reporting increased unemployment compared to controls in adulthood. Early unemployment was associated with increased smoking and psychological distress at age 30 compared to a control group. After controlling for past behaviour, symptoms and social background, with men early unemployment was associated with increased anxiety and depression at 30 compared to controls. For women, both late and early unemployment resulted in higher psychological symptoms in adulthood compared to controls. Although the Swedish context of the study limits applicability to the UK, the study provides strong evidence to suggest that early unemployment can lead to poor mental health in adulthood.

In sum, unemployment at a young age was likely to result in psychological and somatic difficulties in later adulthood. This is confirmed by an American study by Mossakowski (2009), who used The National Longitudinal Survey of Youth (cited in Mossakowski, 2009) to study past unemployment experience and transitioning into adulthood 15 years later. Results showed that a longer duration of unemployment predicted depressive symptoms among young adults compared to those who were in employment. Early unemployment status was significantly related with depression at age 29 to 37 and when prior depression was controlled for the effects were still significant (Mossakowski, 2009). More UK longitudinal studies are needed in order to show the trajectory of mental health difficulties in adults

that have experienced youth unemployment. However, a UK review by Bell and Blanchflower (2010) found that longer bouts of unemployment resulted in longer bouts of depression. Unemployed individuals were less happy and youth unemployment led to decreased happiness 20 years later, thus the adverse effects of unemployment had wider reaching consequences in later life. They also argued that 16 to 24 year olds have been more adversely affected by the recession compared to adults. Thus research on socially disengaged young people is not only important but timely.

A possible explanation of the long term effects of youth unemployment was provided by Paul and Tominey (2004, p.2), they argued that unemployment left a 'wage scar', to which long term earnings were negatively affected and took time to recover. They found that youth unemployment in women was associated with being paid £2.00 less per hour 20 years later compared to those with no youth unemployment. In men the deficit in wages was twice that of women. Men who had experienced youth unemployment were paid £4.00 less per hour compared to men who had not experienced youth unemployment.

3.7 Summary

Having stressed the risk, costs, negative outcomes and burdens of youth disengagement, what is clear is that the socially disengaged populations are an intricate and tedious group. They are often entangled in a web of social disadvantage which can result in mental health problems (Benjet, et al, 2012).

Socially disengaged youth require an increasing amount of assistance and attention to prevent sustained social exclusion, social isolation and economic strain. Of significant concern is the negative impact of social disengagement and inactivity on mental health and wellbeing with economic inactivity in youth having longstanding negative effects in adulthood (The Social Exclusion Unit, 1999). The debilitating nature of mental health disorders makes mental health a priority for research.

What previous literature has succeeded in doing is showing an array of issues which affect this population and society at large. Overall the risk factors of the socially disengaged youth have been well recognized and previous research has exposed the social, psychological, and economic contexts of youth disengagement.

A limitation of these studies is that many employ correlation designs, thus, causation is not established. However, by using baseline information and controlling for confounds research has continually shown the negative impact of unemployment, low educational attainment, social disadvantage and social inactivity on mental health and wellbeing in the general population and more so in the youth population (Bell & Blanchflower, 2010).

The impetus of the present study is found from previous research and policy, which demonstrates the prioritization of educational and economic outcomes concerning the NEET category (Yates & Payne, 2006), thereby overshadowing mental health and wellbeing. While it is important to move young

people into the workforce, we can avoid a cycle of broken employment by ensuring that young people's mental health and wellbeing are addressed, enabling them to maintain and commit to the workforce, should the opportunity arise. This is not suggesting that areas such as employment and education are less important, but that mental health and wellbeing should be prioritized in conjunction with economic, educational, employment and political domains.

In light of the literature, the present study aims to provide additional information on the mental health status of socially disengaged young people in the general population who are NEET. From this study, the extent of mental health difficulties within this vulnerable subgroup will be assessed.

3. 8 Summary of literature review

The literature review from chapters 2 to 3, has considered what is known about mental health and wellbeing in young people, LAC, care leavers and socially disengaged youth. The review has highlighted different perspectives and issues associated with youth mental health and that mental health difficulties are prominent in young people and start from an early age. The literature also emphasises the substantial mental health difficulties faced by young people with immense social disadvantage, however, research within this context is limited. The review focused on prevalence estimates of mental health difficulties and examined socioeconomic factors and risk factors associated with mental health difficulties in vulnerable young people.

What is known is that mental health problems are highly prevalent in the general youth population, with estimates at around 20%. These estimates are twice as high for LAC and for care leavers. In addition it appears that the care leaver population have increased rates of depression. Another issue is that mental health problems can be exacerbated by social disengagement or exclusion, with NEET young people experiencing mental health difficulties, behavioural problems, social loneliness and poor educational attainment.

For the reasons presented in the literature review, care leavers and NEET young people are considered a high risk or vulnerable group. UK studies focused on mental health difficulties in these high risk subgroups are limited. Previous work tends to view care leavers and NEET young people as a single category rather than distinct groups. This is because vulnerable groups are social constructs of vulnerability not clinical constructs, thus there is some crossover between the groups. It could be hypothesised that LAC membership would lead to a higher likelihood of becoming NEET but this was not the focus of the research, which attempts to distinguish these groups and compare them against a general control sample on a range of mental health measures. Additionally, for some measures, previous literature has not documented its use in these high risk categories. With this in mind, the present study is exploratory in nature and aims to augment understanding and existing literature on the psychological profile of care leavers and NEET young people.

Despite the reports that these groups are vulnerable to mental health problems, previous research indicates a lack of mental health literacy in young people and service providers. The review explains

the urgency of early access to treatment; however young people are still reluctant to seek help, thus the secondary aim of the present study is to assess willingness to seek help in these vulnerable groups compared with controls and to evaluate a pilot training course aimed at improving mental health literacy in staff working with care leavers.

What distinguishes this study from previous studies is emphasis on these two high risk groups ages 16 to 25 and the assessment of psychotic like experiences alongside more common mental health disorders and help seeking behaviour. The present study employs a broad range of screening measures some of which have not been used within this context.

4 RESEARCH DESIGN AND METHODOLOGY

4.1 Introduction

This chapter provides an overview of the design and methods used in the present study. The chapter begins by defining the samples and then goes on to the aims and research questions posed by the present study. This is followed by the design, measures, settings, recruitment and data collection procedures. Lastly, an outline of data analysis procedures is given.

4.2 Defining the samples

For the present study mental health need and help seeking are assessed in three independent samples, two high risk samples of young people and a community control sample. The control sample included year 11 pupils aged 15 to 16.

High risk samples included young people who are more vulnerable to mental health difficulties due to the presence of several risk factors. The present study involved two high risk groups reviewed in the previous chapter; the groups included care leavers and young people from the general population who were socially disengaged (not in employment, education or training or NEET). The young people with NEET status were ascertained from those attending The Princes Trust Social Inclusion Programme and had numerous needs as well as NEET status and were likely to have experienced substance misuse, offending and learning difficulties, here this sample is described as NEET+.

4.3 Mental health screening

4.3.1 Aims and research questions

This study aims to document mental health and well-being in young people at an increased risk of developing mental health difficulties compared to controls. This was achieved by conducting a mental health screening that would provide an indication of the level of mental health need in the two high risk groups compared to controls.

The following research questions were addressed;

1. What is the current level of mental health difficulties in care leavers and NEET+ young people compared to an aged matched community control group?
2. Are care leavers and NEET+ young people willing to engage in appropriate help seeking for emotional and behavioural problems compared with a control group?
3. What is the difference between care leavers and NEET+ youth regarding psychotic-like experiences compared with a control group?

4.3.2 Design and methods

A cross-sectional design was used to examine mental health status and help seeking intentions in high risk young people and a community control group. Self-report questionnaires were used to screen for mental health difficulties, risk of psychosis and willingness to seek help.

4.4 Screening settings

4.4.1 Schools

Control participants were recruited from four state secondary schools, schools where located in socially deprived areas in Birmingham (Birmingham City Council Index of Deprivation, 2010). Information for each school plus area profiles for people aged 16 to 64 is provided in Table 4.1.

Table 4.1: School index and information on areas

| School Information | | | | | | |
|---------------------|---------------------------------|------------------|-----------------------------|---|----------------------------|--|
| Sample | Specialty | Number of Pupils | Ward (District) | **Area Profiles & national average (na) | | |
| | | | | Economically inactive (na=23%) | No qualifications (na=15%) | General health problems & very limiting illness (na=10%) |
| School one | Grammar school-math & computing | 936 | Lozells and East Handworth* | 39% | 29% | 16% |
| School two | Business and enterprise | 1025 | Soho (Ladywood)* | 37% | 26% | 14% |
| School three | Technology | 1339 | Nechells (Ladywood)* | 43% | 24% | 15% |
| School four | Art | 966 | Erdington | 23% | 19% | 13% |

*Top 10 most deprived wards in Birmingham (Birmingham City Council Index of Deprivation, 2010)

** Based on the 2011 Census, cited in, Birmingham City Council, Local Area Profiles-economy & labour market, factsheets (Birmingham City Council Index of Deprivation, 2010).

4.4.2 NEET+: Princes Trust Fairbridge Programme

The socially disengaged sample was derived from The Princes Trust Centres situated across England in the most deprived areas. The Princes Trust offer the Fairbridge programme which aims to re-engage

young people who are NEET by involving them in a range of physical activities. Activities such as climbing, canoeing and art are intended to provide foundational skills, which will facilitate entry into employment and education. The Fairbridge programme helps young people across UK who have experienced; low self-esteem, mental health issues, poor literacy and numeracy skills, never working, learning disabilities, peer problems and substance abuse. The Princes Trust emphasise that youth who need help the most are individuals who are young offenders. Often young people from challenging family backgrounds fall into the NEET category, which can lead to social exclusion. The Princes Trust Fairbridge programme aims to tackle social exclusion and re-engage young people back in to society.

4.4.3 Care leavers

The majority of care leavers were recruited from Birmingham Local Authority Eve Brook House. Eve Brook House provides a 16+ care leavers service. Aftercare workers and social workers work with young people to create pathway plans and to support young people as they transition into independence. Here, care leavers can receive support, referrals, visits and financial assistance. Eve Brook House also partner with St Basils to find suitable accommodation for those leaving local authority care. 'St Basils is a youth agency which uses housing as the medium to work with young people aged 16 to 25 to enable them to find and keep a home, to develop their confidence, skills and opportunities and to prevent homelessness. To do this they provide a range of services to young people in Birmingham and some of the surrounding areas of the West Midlands' (St Basils, Preventing Youth Homelessness, 2007, p.2). Thus St Basils provided an additional setting in which to access care leavers.

4.5. Recruitment

4.5.1 Recruiting School Students

A comprehensive list of Birmingham school profiles was provided by Birmingham's Personal Social Health and Education Advisor Wendy Anthony. The list included schools under the healthy schools initiative who have met enhanced healthy schools criteria. The choice of schools was informed by their associated indices of social deprivation and selected schools where from socially deprived areas. However, there is a distinct possibility that children came from other parts of Birmingham to attend these schools. Overall choice of schools was characterised by availability, size and location.

Contact was first made by the researcher via telephone calls and emails, in order to arrange appointments and find out if schools would be interested in the research. Pastoral staffs were contacted and the nature and scope of the research was explained to them. Information sheets informed schools of the research and its association with the NHS Collaboration for Leadership in Applied Health Research and Care (CLAHRC) mental health project (Appendix 2). In addition questionnaires were made available to staff, for them to view prior to their distribution. Pastoral staff passed on the information to Teachers and Head of Years, who were then able to set a date and time for pupils to participate in the research. Data was collected during Personal and Social Education classes and research information packs were distributed and discussed under teacher supervision.

Initially 39 schools were contacted, out of which 7 schools showed an interest in the project. Accessing year 11 pupils was challenging due to exams and timetables and ultimately four secondary schools participated in the research.

4.5.2 Recruiting care leavers

Permission was sought from care leaver team Managers to conduct the research. The research proposal was prepared and discussed with Birmingham Local Authority Operational Manager and Social Workers.

Dr Amanda Skeate was the clinical lead for the NHS LAC service and provided support in accessing this group. The LAC team work with social workers and each social worker has a caseload of up to 50 young people. Therefore contact was made with young people by liaising with social workers, leaving care teams and Birmingham Local Authority teams to access care leavers in Birmingham. Several meetings were attended in order to familiarise the leaving care teams with the research. Leaving care teams and pathway planning teams were responsible for informing care leavers about the study.

Participants were first contacted by leaving care staff, then staff accompanied visits were organised to introduce the study to young people. Data was collected at Eve Brook House where care leavers receive after care support. In addition, a meeting was arranged with the Chief Executive of St Basils Birmingham to discuss the research and find out the number of care leavers using their services. Subsequent emails followed to organise access to potential participants. Once permission was received to contact care leavers at St Basil's accommodation, care leavers were informed of the research by outreach workers. Questionnaires were also administered to care leavers from St Basils' and online versions of the questionnaires were developed to increase the number of participants taking part.

Recruiting care leavers proved challenging, so an advert was placed on the Care Leavers Association website. In addition, information about the research was signposted at Eve Brook House and St Basils residence. Participation was voluntary and each care leaver received £5 for taking part.

4.5.2 Recruiting socially disengaged youth (NEET+)

The Princes Trust Fairbridge Programme aims to promote social inclusion by engaging young people struggling with education, employment and the justice system. Meetings were arranged with The Princes Trust manager Claire Rigby to discuss the feasibility of the research. Once permission was received to go ahead with the research, outreach workers conducting The Princes Trust Fairbridge Programme informed the young people about the research.

The Princes Trust Fairbridge Programme has scheduled activities every month to engage young people who are NEET. Recruitment was spread out over two years in order to coincide with new intakes of young people at the various sites.

The socially disengaged youth sample was recruited from The Princes Trust Fairbridge branches across England, The Princes Trust Fairbridge Services in Birmingham, Manchester, Southampton, Bristol and London (Kennington) were involved in data collection. Managers were contacted over the phone, after which meetings were arranged. Meetings provided an opportunity to discuss the research protocol and develop a plan of action.

4.6 Procedure and ethical considerations

4.6.1 Ethics

Under the framework established by the healthy schools initiative, LAC team and The Princes Trust, the research was supervised by teachers, social workers, outreach workers and the CLAHRC research team. If any young person disclosed information suggesting distress to self or others, there was a duty of care to communicate this to the teacher, parents, social worker and outreach workers, which was made clear to participants and formed part of ethical approval. Participants were advised to contact their GP and access the youth mental health website developed by the CLAHRC project team (www.youthspace.me) for further assistance.

4.6.2 Consent

After research was introduced into the various settings, through relevant staff and permission obtained, information sheets were provided and displayed on notice boards to inform young people about the research. Information sheets included information on the aim, purpose and dissemination of findings. For the school samples pupils were required to give information sheets to their parents, who were given the opportunity to opt out of the research if they did not want their child to participate. Young people were informed that participation was voluntary and data collected would be anonymous and confidential. All those intending to participate in the study were required to give informed consent before completing the questionnaire (Appendix 3).

4.7 Inclusion and exclusion criteria:

4.1 Inclusion criteria:

- Care Leavers age 16 to 25 who were involved in education, training or employment and were able to give informed consent, were included in the study.
- NEET+ young people age 16-25 were included in the study if they had not been in care and were able to give informed consent.
- School Students aged 15 to 16 not in care, were included in the study

4.2 Exclusion criteria:

- Participants who had learning difficulties or were unable to understand the questionnaire
- Participants deemed unfit to take part by social workers, teachers or outreach and development workers.

Note: Care leavers and NEET+ samples were considered as separate groups

4.8 Measures

4.8.1 Sociodemographic information

Demographics were collected from the various samples, these included; age, gender and ethnicity.

4.8.2 Strengths and Difficulties Questionnaire (SDQ)

This measure is a self-report questionnaire consisting of 25 attributes, which are divided into five subscales. The scales were based on classifications from the child psychopathology DSM-IV and ICD-10 (Goodman, 1997). The subscales measure conduct problems, Hyperactivity, emotional symptoms, peer relationship difficulties and pro-social skills. The subscales except pro-social, are added together to form a total difficulties score between 0 and 40. The pro-social subscale measures positive interaction with others, which has been linked with resilience. Items on the questionnaire were scored on a 3 point scale; 1= 'not true', 2='somewhat true' and 3= 'certainly true' (Goodman, 1997).

The SDQ is widely used to assess mental health and well being in young people and has shown high specificity and sensitivity (Goodman et al, 1998). Goodman and Scott (1999) found that the SDQ was equally as good as the Child Behaviour Checklist (CBCL) in identifying difficulties and significantly better at recognising hyperactivity than the CBCL. The SDQ has also been found to correlate highly with the Rutter Child Scales (Goodman, 1997). Goodman et al, (2000) used the multi-informant SDQ scores to develop a formula to predict psychiatric diagnosis. They found that the SDQ correctly predicted that 81 to 91% of children had a disorder. Of particular interest is a study done by Goodman et al, (2004), they argued that LAC suffer from mental health difficulties which often go unnoticed. Thus they assessed the validity of SDQ predictions in a sample of 1,028 LAC aged 5 to 17. They found that multi-informant SDQ questionnaires indicated a psychiatric diagnosis with a specificity of 80% and sensitivity of 85%. It was concluded that the SDQ can facilitate the recognition of emotional and behavioural disorders in LAC. Van Roy et al, (2006) provided evidence that the SDQ was a valuable

tool in detecting psychological difficulties in older adolescents. A more recent British study concluded that ‘SDQ mean total difficulty scores from any informant generally provide an accurate and unbiased method for monitoring or comparing the mental health of different subgroups’ (Goodman & Goodman, 2011, p.100). Additionally, Goodman and Goodman (2011, p.15) demonstrated that the mean SDQ ‘symptom score closely predicts the prevalence of clinician rated child mental disorder’. These studies provide strong evidence for the utility and validity of the SDQ as a screening instrument (Appendix 4).

4.8.3 Hospital Anxiety and Depression Scale (HADS)

Zigmond and Snaith (1983) developed the HADS questionnaire to assess the probability of anxiety and depression in physically ill patients (Appendix 5). The 14-item self-report questionnaire has two 7 item subscales, measuring states of anxiety and depression. 5 out of 7 items on the depression scale involved the concept of anhedonia. Herrmann (1997) claims the non-specific concept of anhedonia is the strength of HADS Depression (HADS-D). This is because it allows sensitivity to psychological disturbances rather than just somatic symptoms (Herrmann, 1997). Conversely, Brennan et al, (2010) argued that the exclusion of somatic symptoms reduced sensitivity for detecting major depressive disorder. Nevertheless, they concluded that the HADS was useful in screening for emotional distress.

The HADS has 4 point response categories, scored from 0-3. The highest score for HADS-D is 21 and the highest score for HADS Anxiety (HADS-A) is also 21. Total scores for HADS-A and HADS-D are categorised as normal, borderline or abnormal. Bjelland et al, (2002) reviewed literature on the validity of HADS. Information was gathered via factor analyses on the correlation and internal consistency

between the subscales of HADS. The HADS showed similar sensitivity and specificity to more voluminous and comprehensive questionnaires such as The General Health Questionnaire. HADS-Depression and HADS-Anxiety correlated well with other common screening tools, $r=0.06$ and $r=0.08$, respectively. HADS sensitivity and specificity ranged from 0.70-0.90 with a threshold of 8+, thus, they concluded that the concurrent validity of HADS is good to very good. Another study found that the HADS rating scales were not significantly different from the Beck Depression Inventory (Loosman, et al, 2010). In addition, HADS met acceptable standards of reliability (Bjelland, et al, 2002). It was concluded that the HADS had ‘excellent case finding abilities’ (Bjelland, et al, 2002, p.74) and also performs well in assessing depression and anxiety in medical and general populations (Bjelland, et al, 2002; Hinz & Brahler, 2011). In addition, HADS has been shown to provide adequate validity for adolescent populations (White, et al, 1999; Chan, et al, 2010).

Herrmann (1997) also conducted a review where it was concluded that the HADS is a well accepted measure for patients. The validity, reliability, sensitivity and specificity of HADS were found to be acceptable. The two-dimensional format of the HADS was validated by factor analysis. A further advantage is that HADS discriminates well between samples with different intensities of depression and anxiety (Herrmann, 1997). Herrmann (1997, p.33) also noted that the ‘HADS allows longitudinal assessment with repeated testing at intervals of about one week or more and is sensitive to changes in patients emotional state’.

4.8.4 General Help seeking and Actual Help Seeking Questionnaires

The General Help Seeking Questionnaire (GHSQ) identifies general help seeking intentions by assessing the preferred source of help seeking on a 7-point scale; 1=extremely unlikely to seek help from listed source, 7= extremely likely to seek help from listed source, (Rickwood, et al, 2005), see Appendix 7. The GHSQ provides an opportunity to examine type of problem, time of problem and help seeking intentions (Rickwood, et al, 2005). In addition the GHSQ may be used to measure past help seeking experience and the adequacy of support. Participants are asked if they have sought professional help and could rate on a 5-point scale how helpful it was; 1=extremely unhelpful, 5=extremely helpful (Rickwood, et al, 2005). This can be reported as a dichotomy, was help sought or not sought (Rickwood, et al, 2005). For the purpose of this study we will be examining help seeking intentions and if they have previously sought help.

The complementary Actual Help Seeking Questionnaire (AHSQ) assesses any recent help seeking behaviour. Three subscales are used in identifying recent help seeking behaviour; ‘whether or not informal help has been sought, whether or not formal help has been sought and whether no help has been sought’ (Rickwood, et al, 2005, p.8). The AHSQ required participants to indicate if they have recently sought help, (‘yes’ or ‘no’). If ‘yes’ they were asked to indicate who they sought help from (i.e. Counsellor, Psychologist or Psychiatrist) and briefly note the reason they sought help (i.e. emotional or behavioural). The present study will report if help has been sought recently for an emotional or behavioural problem.

Wilson et al, (2005) described the psychometric properties of the GHSQ and the AHSQ. They examined internal and test-retest reliability, predictive and construct validity. Using a sample of 218 secondary school pupils, they measured help seeking intentions. Findings indicated that the GHSQ demonstrated acceptable reliability Cronbach's $\alpha = .83$ and validity. Furthermore, the GHSQ provided a flexible matrix which can be adapted for a specific purpose (Wilson et al, 2005). Yakunina et al, (2010) used the GHSQ to identify help seeking intentions for suicidal ideation, the GHSQ showed an internal consistency of $\alpha = .86$.

Wilson et al, (2005) noted that the GHSQ was sensitive in measuring and discriminating between help seeking intentions and help sources. Wilson et al, (2005) found a significant correlations between the GHSQ and the AHSQ, thus providing evidence for predictive and construct validity. Wilson et al, (2005) provide evidence and support for the reliability and validity of the GHSQ and the AHSQ.

4.8.5 PROD screen

The Detection of Early Psychosis (DEEP) project in Finland designed the PROD-screen (Heinimaa et al, 2003) to screen for prodromal symptomatology or vulnerability to psychosis (Appendix 6). The questionnaire focuses on psychotic-like experiences (PLEs) such as, delusions, hallucinations and cognitive difficulties (Heinimaa, et al, 2003). The PROD consists of 21 questions on general mental health and PLEs. In the present study the PROD-screen examined symptoms over the past 12 months. PLEs were assessed in twelve of the questions and general mental health symptoms were included in 9 of the questions. Scores can be calculated for, PLEs, general mental health symptoms and total symptoms of psychosis risk. Typical symptoms of psychosis reported by previous research were assessed in the PROD. The PROD-screen questions were based on the Interview for the Retrospective

Assessment of the Onset of Schizophrenia, (Häfner, et al, 1992, cited in Heinimaa, et al, 2003), Bonn Scale for the Assessment of Basic Symptoms (Gross, 1987, cited in Heinimaa, 2003) and the Structured Interview for Prodromal Symptoms (SIPS, McGlashan, 1998, cited in Heinimaa et al, 2003). Symptoms were also included to cover a broad range of difficulties.

Heinimaa et al, 2003 claim that the PROD-screen is not difficult to complete and has good acceptability. The PROD-screen was able to differentiate between those who were vulnerable to developing psychosis and those who were not, with a sensitivity of 80% and a specificity of 75%, furthermore, Heinimaa et al, 2003, assessed the concordant validity of the PROD by comparing it with The Structured Interview for Prodromal Symptoms (SIPS) measure, which is used to determine pre psychotic symptoms and identify psychotic states (Miller et al, 1999).

When the cut off point was three, the PROD-screen correctly identified 79% of prodromal cases when compared to SIPS, when the cutoff point was two 77% of cases were correctly identified (Heinimaa, et al, 2003). For this study, cut off points were set at three. This was deemed appropriate for the present study and follows Heinimaa et al, (2003), recommendations. Validity of the PROD was also reported as 77% (Heinimaa, et al, 2003). Therman et al, (2011, p.347) used item factor analysis and found, ‘content validity of nearly all the items of the PROD-screen, and the explained variance was satisfactorily high’.

Generally, the PROD-screen has demonstrated acceptable sensitivity and specificity when compared with the SIPS and has been used for both general and clinical populations.

The questionnaires employed are widely used and have proven to be robust measures in terms of reliability, validity and sensitivity and the combination of measures provided a comprehensive picture of the level of mental health need and the help seeking intention of young people.

4.9 Data analysis

Prior to data analysis data cleansing was undertaken. The data were screened for errors by scrutinizing descriptive and frequency distributions. Examining minimum and maximum values and frequencies enabled the identification of miscoded data, missing values and data that was out of the range of scores.

Data were analysed using the Statistical Package for the Social Sciences (SPSS) version 19.

Descriptive statistics were obtained for key dependent variables. All variables were screened to find out if assumptions for parametric statistics were met. By running The Kolmogorov-Smirnov test and calculating the degree of skewness; dividing kurtosis value by standard errors (Kim, 2013), it was revealed that data was not normally distributed (Table 6.2 & Table 7.2) and non parametric analysis was used. The Mann Whitney U Test has been recommended as one of the best strategies for comparing two independent groups (Pero-Cebollero & Guardia-Olmos, 2013) as a result this test was employed for data analysis; alpha was set at 0.05 (2-tailed).

4.10 Missing data

Missing data analysis was conducted and blank responses were identified. Four responses were missing concerning if a relative had experienced a mental illness; consequently they were omitted from the analysis. For the GHSQ which measures willingness to seek help, responses that were incomplete or blank were not included in the analysis, this constituted 8% of control sample. In addition 6% of the control sample did not indicate if they had recently sought help for mental health difficulties on the AHSQ. For the SDQ and HADS missing data was also excluded from the analysis, thus sample sizes varied across measures.

Regarding the PROD-screen Hurtig et al, (2011, p.21) suggested that 'PROD was valid if there were less than four answers missing out of the 21 items and less than three answers missing out of the 12 specific items'. Based on this premise, data was either omitted from the analysis or where applicable; the missing data was replaced with the mean score of the participant.

5 RESULTS: THE MENTAL HEALTH OF LOCAL AUTHORITY CARE LEAVERS & SOCIALLY DISENGAGED YOUTH (NEET+)

This chapter draws a parallel between care leavers, NEET+ young people and a control sample, by highlighting differences in reported mental health difficulties, help seeking, emotional, behavioural and psychotic-like experiences (PLEs).

This chapter presents findings from the present study and begins by presenting demographic, descriptive and prevalence information on the level of mental health difficulties and help seeking behaviour.

The Mann Whitney U test is then used to test whether statistically significant differences occurred between care leavers and NEET+ young people, in comparison to a control group, for the main study variables. Each research question is addressed in turn and the chapter concludes with a summary of findings.

5.1 Demographics

5.1.1 Socio-demographic variables

The vulnerable samples differed significantly from controls on all sociodemographic variables, with the exception of the NEET+ sample which did not differ by gender ($X^2=2.847$, 2df, $p>0.05$), when compared to controls. Demographic information for the NEET+ sample, care leaver sample and control sample is shown in Table 5.1.

Age, gender, ethnicity and family mental health for care leavers, NEET+ youth, and controls

*2 missing for NEET+, 1 for care leavers

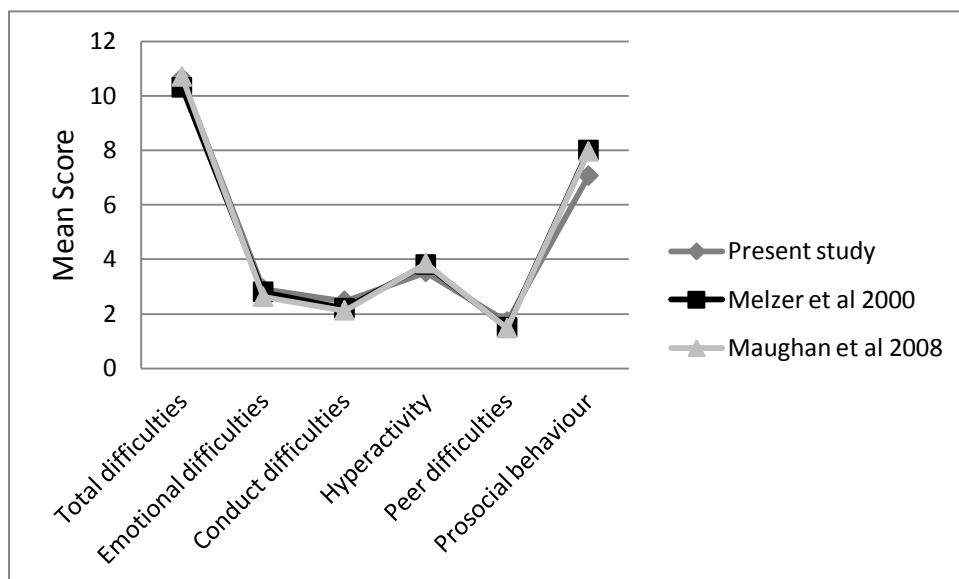
5.2 Distribution of mental health and help seeking scores for controls, care leavers and NEET+ youth

The normality of distribution for the control sample and care leavers sample was assessed using the Kolmogorov-Smirnov test. For the care leaver scores; total difficulties, hyperactivity, anxiety, informal help seeking and total help seeking were distributed normally. However, for the majority of subscales the test indicated non normal distributions. For the NEET+ sample scores for informal help seeking, total help seeking, depression, and total difficulties were distributed normally. However, for the majority of subscales the test revealed non normal distributions and for the control group data was skewed for all subscales. As a result, non parametric analysis was used.

5.3 Descriptive statistics

Descriptive statistics and the mean scores for the control group in the present study compared with previous studies are depicted in Table 5.3 and Figure 5.1.

Figure 5.1: Mean SDQ scores for controls compared to care leavers



5.4 Proportion of care leavers & NEET + youth with mental health difficulties compared with controls

5.4.1 Prevalence rates

The data indicates that 31/74 (41.9%) care leavers and 37/84 (44%) of NEET+ youth scored within abnormal range for SDQ total difficulties scores, indicating a probable mental health disorder. In comparison 15.8% of controls scored in the abnormal range. For care leavers 31.1% had a probable anxiety disorder and 33.3% for NEET+ youth, compared to 19% of controls. While for depression 13.5% of care leavers and 10.7% of NEET+ youth had abnormal scores compared to 4.7% of controls. For willingness to seek help, findings showed that 50% of care leavers, 61.9% of NEET+ youth and 50.2% of controls were unlikely to seek formal help for emotional and behavioural difficulties (GHSQ). Just 4.0% of controls (school students), 5.4% of care leavers and 9.5% of NEET+ youth were likely to seek formal help. For specific psychosis like symptoms, with a cut off of 3/12, 49% of care leavers and 51% of NEET+ youth showed vulnerability to psychosis compared to 30.7% of controls (Table 5.2).

When scores were categorised into normal, abnormal and borderline range, Chi square revealed that, care leavers scores differed significantly from controls on almost all subscales, excluding conduct difficulties ($X^2=3.795$, 2df, $p>0.05$), pro-social difficulties ($X^2=2.714$, 2df, $p>0.05$) and formal help seeking ($X^2=10.63$, 2df, $p>0.05$). For NEET+ youth the range of scores for most subscales differed significantly from controls, with the exception of conduct ($X^2=4.246$, 2df, $p>0.05$) and pro-social difficulties ($X^2=5.641$, 2df, $p>0.05$), see Table 5.2.

Table 5.2

Prevalence of mental health difficulties and willingness to seek help in controls, care leavers and NEET

| Measures | Control | | Care Leavers | | | | NEET | | | |
|---|---------|------|--------------|------|----------------|------|------|------|----------------|------|
| | N | % | N | % | X ² | p* | N | % | X ² | p* |
| Strengths and difficulties (SDQ) | | | | | | | | | | |
| Total Difficulties | | | | | 34.28 | .001 | | | 40.10 | .001 |
| Normal | 328 | 73.2 | 30 | 40.5 | | | 34 | 40.5 | | |
| Borderline | 49 | 10.9 | 13 | 17.6 | | | 13 | 15.5 | | |
| Abnormal | 71 | 15.8 | 31 | 41.9 | | | 37 | 44.0 | | |
| Emotional difficulties | | | | | 28.26 | .001 | | | 9.002 | .011 |
| Normal | 301 | 67.2 | 26 | 35.1 | | | 43 | 51.2 | | |
| Borderline | 39 | 8.7 | 11 | 14.9 | | | 8 | 9.5 | | |
| Abnormal | 108 | 24.1 | 37 | 50.0 | | | 33 | 39.3 | | |
| Conduct difficulties | | | | | 3.795 | .150 | | | 4.246 | .120 |
| Normal | 246 | 54.9 | 37 | 50.0 | | | 43 | 51.2 | | |
| Borderline | 102 | 22.8 | 13 | 17.6 | | | 14 | 16.7 | | |
| Abnormal | 100 | 22.3 | 24 | 32.4 | | | 27 | 32.1 | | |
| Hyperactivity | | | | | 19.77 | .001 | | | 5.768 | .056 |
| Normal | 383 | 85.5 | 50 | 67.6 | | | 63 | 75.0 | | |
| Borderline | 33 | 7.4 | 7 | 9.5 | | | 11 | 13.1 | | |
| Abnormal | 32 | 7.1 | 17 | 23.0 | | | 10 | 11.9 | | |
| Peer difficulties | | | | | 46.27 | .001 | | | 85.71 | .001 |
| Normal | 334 | 74.6 | 29 | 39.2 | | | 25 | 29.8 | | |
| Borderline | 61 | 13.6 | 15 | 20.3 | | | 15 | 17.9 | | |
| Abnormal | 53 | 11.8 | 30 | 40.5 | | | 44 | 52.4 | | |
| Pro-social behaviour | | | | | 2.714 | .230 | | | 5.641 | .060 |
| Normal | 343 | 76.6 | 63 | 85.1 | | | 54 | 64.3 | | |
| Borderline | 55 | 12.3 | 6 | 8.1 | | | 16 | 19.0 | | |
| Abnormal | 50 | 11.2 | 5 | 6.8 | | | 14 | 16.7 | | |
| Total | 448 | | 74 | | | | 84 | | | |
| Hospital Anxiety and Depression Scale (HADS) | | | | | | | | | | |
| Anxiety | | | | | 7.908 | .019 | | | 9.351 | .009 |
| Normal | 260 | 58.0 | 31 | 41.9 | | | 37 | 44.0 | | |
| Borderline | 103 | 23.0 | 20 | 27.0 | | | 19 | 22.6 | | |
| Abnormal | 85 | 19.0 | 23 | 31.1 | | | 28 | 33.3 | | |
| Depression | | | | | 9.216 | .010 | | | 28.82 | .012 |
| Normal | 360 | 80.4 | 52 | 70.3 | | | 56 | 66.7 | | |
| Borderline | 67 | 15.0 | 12 | 16.2 | | | 19 | 22.6 | | |
| Abnormal | 21 | 4.7 | 10 | 13.5 | | | 9 | 10.7 | | |
| Total | 448 | | 74 | | | | 84 | | | |
| Willingness to seek help (GHSQ) | | | | | | | | | | |
| Average Formal help seeking | | | | | 10.63 | 0.59 | | | 15.98 | .007 |
| Extremely Unlikely | 132 | 29.5 | 21 | 28.4 | | | 17 | 20.2 | | |
| Unlikely | 225 | 50.2 | 37 | 50.0 | | | 52 | 61.9 | | |
| Neutral | 33 | 7.4 | 11 | 14.9 | | | 7 | 8.3 | | |
| Likely | 18 | 4.0 | 4 | 5.4 | | | 8 | 9.5 | | |
| Extremely Likely | 4 | 0.9 | 1 | 1.4 | | | - | - | | |
| Average Informal help seeking | | | | | 18.46 | .002 | | | 29.78 | .001 |
| Extremely Unlikely | 6 | 1.3 | 4 | 5.4 | | | 5 | 6.0 | | |
| Unlikely | 103 | 23.0 | 28 | 37.8 | | | 28 | 33.3 | | |
| Neutral | 94 | 21.0 | 13 | 17.6 | | | 25 | 29.8 | | |
| Likely | 187 | 41.7 | 27 | 36.5 | | | 18 | 21.4 | | |
| Extremely Likely | 22 | 4.9 | 2 | 2.7 | | | 8 | 9.5 | | |
| Total | 412 | | 74 | | | | 84 | | | |
| Actual help seeking (AHSQ) | | | | | | | | | | |
| ¹ Recent help sought | | | | | 20.54 | .001 | | | 12.00 | .002 |
| Yes | 150 | 35.7 | 44 | 59.5 | | | 42 | 50.0 | | |
| No | 269 | 64.3 | 30 | 40.5 | | | 42 | 50.0 | | |
| Total | 419 | | 74 | | | | 84 | | | |
| Vulnerability to psychosis (PROD) | | | | | | | | | | |
| General mental health symptoms | | | | | 13.06 | .001 | | | 19.07 | .001 |
| 0-2 | 194 | 43.3 | 24 | 32.5 | | | 20 | 23.8 | | |
| 3-5 | 104 | 23.2 | 24 | 32.5 | | | 20 | 23.8 | | |
| 6-9 | 60 | 13.4 | 19 | 25.8 | | | 32 | 38.0 | | |
| PLEs | | | | | 11.24 | .004 | | | 13.75 | .001 |
| 0-2 | 221 | 49.3 | 31 | 41.9 | | | 29 | 34.5 | | |
| 3-5 | 74 | 16.6 | 23 | 31.2 | | | 10 | 12.0 | | |
| 6-12 | 63 | 14.1 | 13 | 17.8 | | | 33 | 39.4 | | |
| Total | 358 | | 67 | | | | 72 | | | |

¹6.5% missing values for controls, *Chi square test to compare with controls, p<0.05

5.5 Rates of disorders in care leavers compared to controls

5.5.1 *Research question 1*: What is the current level of mental health difficulties in care leavers and NEET+ youth compared to a control group?

5.5.1.1 SDQ

Descriptive statistics indicated that for SDQ total difficulties score care leavers had a mean of 15.64 (SD=7.13) and NEET+ youth had a mean of 16.40 (SD=7.08). In comparison controls had a mean score of 10.64 (SD=5.25).

A Mann-Whitney U test was conducted to evaluate the differences in mental health and help seeking (Table 5.3). Results for SDQ total difficulties scores showed a significant difference, $U=9662.0$, $Z=-5.762$, $p=0.001$, showing that on average care leavers had significantly more overall difficulties than controls. NEET+ youth also had significantly more total difficulties than controls $U=9435.0$, $Z=-7.268$, $p=0.001$.

Results of the test showed that the SDQ emotional difficulties scores were significant for care leavers, $U=11051.0$, $Z=-4.641$, $p=0.001$ and NEET+ youth, $U=15069.0$, $Z=-2.928$, $p=.003$, indicating that care leavers and NEET+ youth reported significantly more emotional difficulties compared to controls.

For SDQ conduct difficulties the differences between care leavers and controls was not significant $U=15236.5$, $Z=-1.134$, $p=.257$. Similarly, there was no significant difference between controls and NEET+ youth for conduct difficulties, $U=17445.5$, $Z=-1.080$, $p=.280$.

Hyperactivity showed a significant difference between care leavers and controls $U=12628.5$, $Z=-3.321$, $p=0.001$, and NEET+ youth compared to controls $U=14415.0$, $Z=-3.444$, $p=0.001$, indicating that on average care leavers and NEET+ youth reported significantly more hyperactivity than controls.

Results for peer difficulties were statistically significant, with care leavers, $U=8449.0$, $Z=-6.918$, $p=0.001$ and NEET+ youth, $U=7950.0$, $Z=-8.582$, $p=0.001$, reporting significantly more peer difficulties than controls. Indicating that care leavers and NEET+ youth had significantly more peer difficulties than controls.

Pro-social subscales showed a significant difference between care leavers and controls, $U=14181$, $Z=-2.015$, $p=.044$, with care leavers reporting higher pro-social behaviour than controls. However, for NEET+ youth no significant difference was found for pro-social behaviour when compared to controls, $U=17769.0$, $Z=-.818$, $p=.413$.

5.5.1.2 HADS

Descriptive statistics indicated that for HADS-Anxiety care leavers had a mean of 8.39 ($SD=4.50$) and NEET+ youth had a mean of 8.29 ($SD=4.43$). In comparison controls had a mean score of 7.08 ($SD=3.98$).

A Mann Whitney U test found that on average care leavers scored significantly higher for anxiety compared to controls $U=13750.5$, $Z=-2.367$, $p=.018$. When NEET+ youth were compared to controls for anxiety, there was a statistically significant difference, $U=15448.0$, $Z=-2.612$, $p=.009$.

For HADS-Depression descriptive statistics indicated that care leavers had a mean of 6.04 (SD=3.83) and NEET+ youth had a mean of 6.31(SD=3.1). In comparison controls had a mean score of 4.77 (SD=3.00).

A Mann Whitney U test showed that on average care leavers scored significantly higher for depression compared to controls, $U=13338.5$, $Z=-2.708$, $p=.007$. NEET+ youth also scored significantly higher for depression compared to controls $U=13334.5$, $Z=-4.262$, $p=0.001$.

5.5.1.3 Summary of SDQ and HADS results

Overall results showed that the rate of mental health difficulties were increased in care leavers and NEET+ youth compared to controls. There was a preponderance of care leavers and NEET+ youth who reported emotional, hyperactivity, peer, anxiety and depressive problems compared to controls. No significant difference was found for conduct difficulties for both care leavers and NEET+ youth. Surprisingly, pro-social skills were significantly better in care leavers than controls. While for NEET+ youth there was no significant difference for pro-social behaviour compared to controls. However, the aggregate of SDQ difficulties was significantly higher in care leavers and NEET+ youth compared to controls.

5.5.2 *Research Question 2*: Are care leavers and NEET+ young people willing to engage in more help seeking for emotional and behavioural problems compared with a control group?

5.5.2.1 GHSQ & AHSQ

The GHSQ total willingness to seek help comprised of formal, informal and other help seeking sources. For total willingness to seek help care leavers had a mean score of 27.25 (SD=9.93) and NEET+ young people had a mean score of 28.18 (SD=9.79). In comparison, controls had a mean score of 28.36 (SD=8.97).

A Mann Whitney U test showed no significant differences between care leavers and controls for GHSQ total willingness to seek help, $U=13735.5$, $Z=-1.357$, $p=.175$. When compared with controls, NEET+ youth results showed, $U=16806.0$, $Z=-.416$, $p=.677$, indicating no significant difference for total willingness to seek help.

There was no statistically significant difference between care leavers and controls for the GHSQ willingness to seek formal help, $U=13864.5$, $Z=-1.245$, $p=.213$. In contrast, for NEET+ youth results showed a statistically significant difference for formal help seeking compared to controls, $U=14114.5$, $Z=-2.673$, $p=.008$.

For the GHSQ willingness to seek informal help, on average the control sample were significantly more willing to seek informal help than care leavers, $U=11874.0$, $Z=-3.034$, $p=.002$. While for

NEET+ youth willingness to seek informal help showed a significant difference, $U=13686.5$, $Z=-3.026$, $p=.002$, indicating that on average the control sample sought significantly more informal help compared to NEET+ youth.

For AHSQ results showed that on average care leavers engaged in significantly more recent actual help seeking than controls, $U=11835.0$, $Z=-3.837$, $p=0.001$. For NEET+ youth recent help seeking behaviour showed, $U=15099.0$, $Z=-2.443$, $p=.015$, indicating that on average NEET+ youth engaged in significantly more recent actual help seeking than controls.

5.5.2.2 Summary of GHSQ and AHSQ results

Overall results showed that care leavers and controls did not differ significantly for willingness to seek formal help. However, controls were significantly more willing to seek informal help compared to care leavers. Overall care leavers engaged in more recent help seeking than controls. NEET+ young people were significantly more willing to seek formal help than controls and engaged in significantly more recent help seeking than controls. Controls however, were significantly more willing to seek informal help when compared to NEET+ youth.

5.5.3 *Research question 3*: What is the difference between care leavers and NEET+ youth regarding psychotic-like experiences compared with a control group?

5.5.3.1 PROD

Results for the PROD general mental health symptoms showed, $U=9273.5$, $Z=-2.985$, $p=.003$, indicating that care leavers reported significantly higher general mental health symptoms compared to controls. NEET+ youth also reported significantly higher general mental health symptoms compared to controls, $U=7247.0$, $Z=-5.926$, $p=0.001$.

For vulnerability to psychosis care leavers had a mean score of 7.28 ($SD=5.67$) and NEET+ youth had a mean of 9.56 ($SD= 6.06$), while controls had a mean score of 5.24 ($SD=5.16$).

A Mann Whitney U test revealed a statistically significant difference, with care leavers reporting significantly more PLEs than controls, $U=9681.5$, $Z=-2.566$, $p=.010$. NEET+ youth also reported a statistically significant difference for PLEs compared to controls, $U=8229.5$, $Z=-4.946$, $p=0.001$.

PROD total symptoms showed, $U=9317.0$, $Z=-2.921$, $p=.003$, revealing that on average care leavers reported significantly more overall symptoms for psychosis risk and mental health difficulties.

NEET+ youth also reported significantly more overall symptoms than controls, $U=7389.5$, $Z=-5.748$, $p=0.001$.

For the PROD general symptom severity scores, on average care leavers reported general mental health symptoms as significantly more severe than controls, $U=9194.0$, $Z=-3.053$, $p=.002$. When compared with controls NEET+ youth also reported significantly more severe general symptoms compared to controls, $U=7369.5$, $Z=-5.764$, $p=0.001$.

Results for the PROD PLEs severity showed, $U=9501.0$, $Z=-2.741$, $p=.006$, indicating that care leavers reported significantly greater symptom severity for PLEs. Similarly, NEET+ youth reported significantly more specific symptom (PLEs) severity compared to controls $U=8383.5$, $Z=-4.741$, $p=0.001$. PROD total symptom severity score showed a significant difference between care leavers and controls, $U=9515.0$, $Z=-2.695$, $p=.007$, with care leavers reporting more severe symptoms overall compared to controls. Overall NEET+ youth reported their symptoms as significantly more severe compared to controls, $U=7680.0$, $Z=-5.428$, $p=0.001$.

5.5.3.2 Summary of PROD results

Care leavers and NEET+ youth reported greater mental health difficulties than controls and significantly more PLEs. Furthermore, they rated symptoms as significantly more severe than controls, suggesting that NEET+ youth and care leavers are at a higher risk of developing psychosis.

Table 5.3

| <i>Means, standard deviations (SD) and Mann Whitney U test for care leavers and NEET groups vs. controls for mental health ratings and help seeking.</i> | | | | | | | | | | |
|--|----------|--------------|---------------------------|--------------|----------------|------|-------------------|--------------|----------------|------|
| Measures | Controls | | Care Leavers vs. Controls | | | | NEET vs. Controls | | | |
| | N | Mean (SD) | N | Mean (SD) | Mann Whitney U | | N | Mean(SD) | Mann Whitney U | |
| | | | | | z | p | | | z | p |
| Strengths and difficulties (SDQ) | 448 | | 74 | | | | 84 | | | |
| Total Difficulties | | 10.64 (5.25) | | 15.64 (7.13) | -5.762 | .001 | | 16.40 (7.08) | -7.268 | .001 |
| Emotional difficulties | | 2.90 (2.30) | | 4.34 (2.50) | -4.641 | .001 | | 3.71 (2.44) | -2.928 | .003 |
| Conduct difficulties | | 2.47 (1.73) | | 2.97 (2.35) | -1.134 | .257 | | 2.63 (1.64) | -1.080 | .280 |
| Hyperactivity | | 3.53 (1.96) | | 4.51 (2.38) | -3.321 | .001 | | 4.30 (1.96) | -3.444 | .001 |
| Peer difficulties | | 1.71 (1.45) | | 3.26 (1.88) | -6.918 | .001 | | 3.63 (1.92) | -8.582 | .001 |
| Pro-social behaviour | | 7.06 (2.12) | | 7.59 (1.88) | -2.015 | .044 | | 6.85 (2.33) | -.818 | .413 |
| Hospital Anxiety and Depression Scale (HADS) | 448 | | 74 | | | | 84 | | | |
| Anxiety | | 7.08 (3.98) | | 8.39 (4.50) | -2.357 | .018 | | 8.29 (4.43) | -2.612 | .009 |
| Depression | | 4.77 (3.00) | | 6.04 (3.83) | -2.708 | .007 | | 6.31 (3.1) | -4.262 | .001 |
| Willingness to seek help (GHSQ) | 412 | | 74 | | | | 84 | | | |
| ¹ Average Formal help seeking | | 4.30 (1.35) | | 3.75 (1.38) | -1.245 | .213 | | 3.81 (1.55) | -2.673 | .008 |
| ² Average Informal help seeking | | 2.26 (1.17) | | 2.45 (1.26) | -3.034 | .002 | | 2.57 (1.14) | -3.026 | .002 |
| ³ Total willingness to seek help | | 28.36 (8.97) | | 27.25 (9.93) | -1.357 | .175 | | 28.13 (9.79) | -.416 | .677 |
| Actual help seeking (AHSQ) | 419 | | 74 | | | | 84 | | | |
| Recent help sought | | - | | - | -3.837 | .001 | | - | -2.443 | 0.15 |
| Vulnerability to psychosis (PROD) | 358 | | 67 | | | | 72 | | | |
| ⁴ General mental health symptoms | | 2.71 (2.50) | | 3.90 (2.99) | -2.985 | .003 | | 4.94 (2.88) | -5.926 | .001 |
| ⁵ PLEs | | 2.53 (2.94) | | 3.39 (3.12) | -2.566 | .010 | | 4.61 (3.57) | -4.946 | .001 |
| ⁶ Total symptoms | | 5.24 (5.16) | | 7.28 (5.67) | -2.921 | .003 | | 9.56 (6.06) | -5.748 | .001 |
| ⁷ Total symptom severity | | 16.69 (16.7) | | 23.30 (19.9) | -2.695 | .007 | | 29.86 (20.8) | -5.428 | .001 |

Note: *Log10 do not correct skewness of data distribution

¹8% missing values for controls

²8% missing values for controls

³8% missing values for controls

⁴20% missing values for controls, 9.5% for care leavers, 14.3% for NEET+

⁵20% missing values for controls, 9.5% for care leavers, 14.3% for NEET+

⁶20% missing values for controls, 9.5% for care leavers, 14.3% for NEET+

⁷20% missing values for controls, 9.5% for care leavers, 14.3% for NEET+

5.6 Summary of findings

5.6.1 Prevalence of mental health difficulties

Care leavers and NEET+ youth showed a higher level of mental health need compared to the control group. Care leavers had increased significant difficulties compared to controls for all the strengths and difficulties subscales apart from pro-social behaviour and conduct disorder. In addition, care leavers and NEET+ youth scored significantly higher for HADS depression and HADS anxiety compared to controls. Vulnerability to psychosis was increased in care leavers and NEET+ youth, who reported more general mental health difficulties and PLEs than controls. Furthermore, care leavers and NEET+ youth consistently rated their symptoms as significantly more severe than controls. In essence, care leavers and NEET+ youth experience a plethora of mental health difficulties compared to controls, this held true for the majority of mental health subscales.

5.6.2 Willingness to seek help

For care leavers and NEET+ youth, overall willingness to seek help was not significantly different from controls. More specifically, formal help seeking was not significantly different between care leavers and controls. However, NEET+ youth were significantly more willing to seek formal help compared to controls. On average controls were significantly more willing to seek informal help compared care leavers and NEET+ youth. While, care leavers and NEET+ youth reported significantly more recent help seeking behaviour compared to controls.

6 DISCUSSION

6.1 Introduction

The study aimed to assess the mental health and wellbeing of care leavers and NEET+ young people in comparison to a control sample. Quantitative data was generated from self-report questionnaires, which served as a screen for mental health difficulties. This discussion is guided by the following structure. Firstly, a brief overview of findings is given; this is followed by discussing the prevalence of mental health difficulties in controls compared to care leavers. Results regarding pre-psychotic symptoms and willingness to seek help for an emotional or behavioural problem are then discussed. Following the same format findings for NEET+ young people are discussed in comparison to controls. The chapter concludes with; methodological limitations, implications and a summary of the findings.

6.2 Review of Results

The central finding from the present study was that care leavers and NEET+ young people had substantially higher scores for mental health difficulties on almost all scales compared to controls, with pro-social skills and conduct disorder being the exception. Generally, emotional difficulties and peer difficulties were the most prevalent compared to other subscales.

It is important to note that the control group were less likely to have passed through the same transitions as vulnerable groups, such as transitioning into further education, employment and moving out, all of which add to mental stress. Thus higher prevalence rates in care leavers and

NEET+ young people may be due to experiencing more transitions, thus findings should be interpreted with caution.

6.2.1 Prevalence of mental health difficulties for controls in the present study compared to previous studies

In the present study 15.8% of controls scored in the abnormal range for SDQ total difficulties, indicating probable mental, emotional and behavioural difficulties. Overall, this estimate is in keeping with previous work which suggests that the prevalence of mental health difficulties in young people within the general population sits at around 15 to 20% (Sawyer, 2000; WHO, 2011).

Findings for emotional and behavioural difficulties in the control sample are directly comparable with other studies, Figure 5.1 illustrates the mean scores of the SDQ subscales for the control group in the present study (N=448) along with comparative SDQ data taken from Meltzer, et al, (2000) who surveyed 4228, 11 to 15 year olds. Comparative data was also taken from Maughan et al, (2008) who used the SDQ to identify emotional and behavioural difficulties in young people (N=2930). Baseline findings for controls in this study replicated previous findings.

6.2.2 Prevalence of mental health difficulties in controls compared to care leavers

Significant differences were found between care leavers and controls on mental health ratings. Results showed that care leavers had increased difficulties on the SDQ difficulties subscales. Interestingly however, care leavers scored higher for pro-social skills.

Care leavers in the present study who were identified as having a probable mental health difficulty (SDQ) accounted for 41.9% of the overall sample. Although previous studies have employed varied methods, the estimates of the present study are in line with previous estimates. Stein and Dixon (2006) found that staff reported 40% of care leavers as having mental health difficulties, including emotional and behavioural difficulties. While, Wade and Dixon (2006) reported that 44% of care leavers had mental health problems. Typically prevalence rates for mental health difficulties in the care leaver population sit at around 40% (Meltzer, et al, 2003; Rodrigues, 2004; McCrystal & McAloney, 2010). The differences in prevalence rates can be attributed to cultural differences, sample differences and differences in methodology. In contrast for children still in care, Marquis and Flynn (2009) found that 31% of LAC scored in the abnormal range for SDQ total difficulties, while Cousins et al, (2010) found that 53.9% of LAC scored in the abnormal range, a much higher estimate.

In the present study 50% of care leavers scored in the abnormal range for SDQ emotional difficulties, the highest of all the subscales. In comparison, controls also scored highest for SDQ emotional difficulties but at 24.1%. A striking paradox is that despite the increased emotional difficulties in care leavers, Rogers (2011) found that the lack of emotional support often signalled the end of care. Moreover, Cashmore and Paxman (2006) found that emotional stability was associated with better aftercare outcomes. The Great Smokey Mountain Study by Costello et al, (2003) found that the majority of 16 year olds in their sample experienced significant emotional disturbance. What is indicated here is that most care leavers and many young people in the general population need a lot of emotional support. Care leavers also scored significantly higher for SDQ hyperactivity and SDQ peer difficulties compared with controls.

Overall, the present study found significant differences between care leavers and controls. Although conduct disorder did not yield a significant difference between care leavers and controls, other work has found conduct disorder to be significantly more in care populations compared to non care populations (McCann, 1996; Meltzer, et al, 2003).

Although much of previous work focuses on prevalence rates in LAC, this served as a baseline for comparing care leaver prevalence rates. The results of the present study clearly indicate that for care leavers emotional difficulties were prominent, depression however was least prominent on the HADS. In contrast, other studies report increased depression, anxiety and conduct disorders (Meltzer, et al, 2003; WHO, 2011). It seems that mental health difficulties during care are carried over when leaving care. Previous research suggests that care leavers experience substantially more mental health difficulties compared to those in care and non care counterparts (Dixon, 2008; Pecora et al, 2009). An important consideration is that McCann used the Achenbach Child Behaviour Checklist and the Kiddie Schedule for Affective Disorders thus methodological differences limit comparability. Nevertheless, it appears that care leaver's experience poorer mental health than young people in the general population and even those still in care. One can speculate from previous work that the reason for this is the multitude of difficulties care leavers face when transitioning to independence (Biehal, et al, 1994; Biehal & Wade, 1996; Stein & Wade, 2000; Stein, 2010; Duncalf, 2010; Fowler, et al, 2011). The good news is that 85.1% of care leavers scored within normal range for pro-social skills compared with 76.6% of controls. The reason for this may be that leaving care provides an opportunity for a fresh start and positive reassessment (Wade and Dixon, 2006). Leaving care can serve as an opportunity to exercise resilience or engage in positive adjustment (Masten, 1994; Luthar & Cicchetti, 2000). Ultimately an increase in pro-social skills suggests a desire for social inclusion and acceptance. On the other hand; it might be

that care leavers in the present study constitute survivors (dependant on leaving care teams) as described by Stein (2004). The care leavers in the present study may be survivors as they were in contact with services, while those in serious difficulties (victims) may have fallen through the net or been engaged by highly specialised services.

6.2.3 HADS- Anxiety and depression in care leavers compared to controls

For the HADS, care leavers consistently scored within the borderline or abnormal range. Care leavers and controls on average reported the most psychological distress for anxiety compared with depression. Overall, 31% of care leavers and 19% of controls scored in abnormal range for HADS anxiety. For HADS depression 13.5% of care leavers and 4.7% of controls had probable depression. Clearly care leavers had increased disorders compared with controls for HADS anxiety and HADS depression.

What the present study shows is that care leavers had greater emotional, peer, conduct and anxiety difficulties compared to controls. Controls had greater difficulties with emotional, conduct and anxiety disorders. For both samples emotional difficulties was at the forefront and appears to be an immense challenge for young people. Especially care leavers who were twice as likely to report abnormal emotional difficulties. In terms of depression present results match that of Steinhausen et al, (1998) who found that depression was the least prevalent mental health difficulty in adolescents. In contrast, Oldehinkel et al, (1999) and White et al, (2009) found that depression was highly prevalent in young people who left care. However, the present study suggests that of all the disorders depression was least prevalent in care leavers and controls.

6.2.4 Psychotic-Like Experiences (PLEs) in care leavers

Current risk of psychosis was assessed in care leavers and findings from the PROD demonstrated that care leavers had a higher level of PLEs, which raises the risk of developing psychosis. Total psychotic like experiences were on average higher in care leavers than controls and care leavers reported far greater severity of symptoms compared to controls. On the PROD more controls reported no symptoms or reported symptoms as not at all distressing than care leavers. However, on average controls reported symptoms as a little distressing, while on average care leavers reported symptoms as somewhat distressing.

The PROD mean score for general mental health symptoms, PLEs, symptom severity and total symptoms were significantly higher for care leavers compared to controls. However, a Swedish study reported higher PLEs mean scores for controls; this is not surprising because the Swedish study used a cut off of 2/12 and in this study a cut off point of 3/12 for PLEs was used. Findings from the PROD indicated high levels of PLEs in both care leavers and controls, with care leavers reporting significantly more PLEs. The present finding that 30.7% of controls are at risk of developing psychosis is in accordance with Koivukangas et al, (2010), who found that at a cut off point of three, over 30% of adolescents screened positive. This estimate is likely to be a result of false positives because Verdoux and Van Os (2002) argued that although psychotic symptoms are highly prevalent in the general population, they rarely convert into psychosis and indeed peak in adolescence. Nevertheless, other work has found that psychosis and psychotic symptoms are common in the general youth population (Lester, et al, 2009; Kessler, et al, 2007; Kelleher, et al, 2012).

A further implication is that anxiety and depression have been found to correlate with increased psychotic like experiences (Johns, et al, 2004; Verdoux & Van Os, 2002; Wigman, et al, 2012). Indeed care leavers scored higher for other disorders such as anxiety and depression and also reported more PLEs. Therefore, PLEs are unlikely to be a passing phase, but a secondary manifestation of underlining mental health difficulties. Unfortunately, previous research has identified poor mental health literacy and a lack of confidence when dealing with psychosis (Jorm, 1997; Yung, et al, 2003). Young people and service providers need to be well informed about mental health and psychosis in order to give and receive appropriate support.

6.2.5 Care leaver's willingness to seek help

GHSQ willingness to seek help was ascertained through formal and informal help seeking preferences. For willingness to seek help from mental health professionals for an emotional or behavioural problem there was no significant difference between care leavers and controls. For both samples the majority of ratings for willingness to seek formal help fell between extremely unlikely and unlikely. For both samples formal help seeking was the least preferred pathway to seeking help. This finding fits in with a number of previous studies by Rickwood et al (2005) and Burns and Rapee (2006). Reasons put forward for the underutilization of mental health services include; lack of knowledge about services, difficulty accessing services and negative experience with services (Rickwood, et al, 2005; Gulliver, et al, 2010). Young people particularly care leavers may avoid help seeking due to hopelessness, isolation, perception of mental health and stigma (Rickwood, et al, 2005; Rothi & Leavey, 2006). If young people are deterred from seeking formal help, this can translate into a delay in treatment, which can lead to poorer overall outcomes (McGlashan & Johannessen, 1996; Birchwood et al, 1997).

There was greater willingness to seek informal help from friends and family compared with formal help seeking. There was a significant difference in informal help seeking between care leavers and controls, with controls engaging in more informal help seeking. Although care leavers were less willing to seek informal help, they were significantly more likely to have sought help in the past two weeks (AHSQ). Care leavers (59.5%) engaged in significantly more recent help seeking behaviour compared to controls (35.7%). A possible explanation for this is that care leavers in this sample had contact with social workers and leaving care staff to collect a weekly allowance and for other aftercare support. Courtney et al, (2001) found that care leavers receive less mental health and therapeutic support; however the present study indicates that any continued contact with any service, no matter how small, can provide an opportunity for help seeking.

6.3 Prevalence of mental health difficulties in NEET+ youth compared with controls.

6.3.1 Review of Results

NEET+ youth scored higher than controls on most of the SDQ subscales, with conduct and pro-social difficulties being the exception.

6.3.2 Emotional, behavioural and mental health difficulties in NEET+ vs. controls

Previous research on the NEET population has been limited in terms of the prevalence of mental health difficulties. However, previous research has been consistent in highlighting the diverse disadvantages associated with this group.

For the NEET+ sample SDQ peer difficulties were the most prevalent with 52.4% scoring in abnormal range compared to 11.8% of controls. This is especially important because research has found that positive peer relationships were associated with resilience (Rutter, et al, 1998, cited in Stein, 2006^a). Furthermore, Nardi et al, (2013) found that 40.7% of NEET had personality disorders such as antisocial behaviour, and reported difficulties with friendships. SDQ emotional difficulties were the second most reported difficulty in NEET+ young people, 39.3% scored in abnormal range. This is also important because Sznitman et al, (2011) argued that emotional wellbeing can reconcile poverty and educational difficulties. For SDQ conduct disorder 32.1% of NEET+ scored in the abnormal range. Regarding controls SDQ emotional difficulties was the most prevalent with 24.1% followed by SDQ conduct difficulties (22.3%). Of relevance here is a study by Romer et al, (2011) which argued that emotional wellbeing could compensate for social disadvantage such as poverty and educational underachievement. If this is the case, a lack of emotional wellbeing may increase susceptibility to the negative effects of social disadvantage. Thus improving emotional wellbeing in NEET+ would be an important area of focus, in order to mitigate the harmful effects of social disadvantage.

The SDQ peer measures tend to focus on isolation, being liked and ability to get on well with others. Over half the NEET+ sample had abnormal SDQ peer scores. That is, NEET+ young people had difficulties with isolation, being liked and getting on with others. This revealed a subtle area of difficulty. The present study concurs with previous work which suggests that social isolation and disengagement results in diminishing social support and poor mental health and wellbeing (Bartley, 1994; The Scottish Executive Social Research, 2005). Moreover, Warr et al, (1988) identified interpersonal contact as one of the necessary vitamins for good wellbeing. Other studies have also recognised that NEET populations experience increased difficulties with relationships (Atkinson

and Hills, 1998, cited in Bynner & Parsons, 2002). This suggests that NEET+ young people lack social capital and personal capital, which includes; social networks, relationships, pro-social behaviour and social isolation (Caspi, et al, 1998). This is of particular importance because studies suggest that a reason for the increased level of mental health need in socially disengaged populations may be etched in economic deprivation and social isolation. According to various studies psychological distress during unemployment was somewhat accounted for by economic deprivation, social disadvantage and social loneliness (Morrell, et al, 1998; Carle & Julkunen, 1998; Creed & Reynolds, 2001; Fryers, et al, 2003). In addition, Reininghaus (2008) found that increased social contact reduced the length of a psychotic episode and improved symptoms. In accordance with this, other studies have found that good social capital and interpersonal skills are linked to improved mental health and educational outcomes in young people (Rothon, et al, 2012; Bond, et al, 2007). It appears that social loneliness hinders the construction of latent functions which are necessary for psychological wellbeing (Johoda, 1981). Therefore poor social networks may result in latent deprivation (Waters & Moore, 2002). Schaufeli (1997) and Koivusilta et al, (2006) found that education was a vital component as well as social status in increasing self-esteem. Self-esteem was found to buffer the negative effects of social disengagement by fostering resilience (Rutter, 1985, cited in McAuley & Davis 2009). What this suggests is that socially disengaged young people need support in developing education, social networks, relationships, pro-social skills and self-esteem. In the present study 64.3% of NEET+ youth scored in the normal range compared to 76.6% of controls for SDQ pro-social skills, this difference was not significant. This corresponds with Walsh, et al, (2011) who found that socially disengaged young offenders did not differ significantly from a normative sample on pro-social skills. These findings imply that NEET or socially disengaged groups were just as pro-social as controls.

Overall, the present study identified 44% of NEET+ young people as having a probable mental health disorder (SDQ). Despite differences in methodology prevalence rates in the present study were similar to other studies. Sefton (2010) showed that 32% of NEET young people reported mental health difficulties. Other studies have also recognised the increased psychological distress in disengaged young people compared to those engaged in work or education (Phillips & Brown, 1998; SEU, 1999; Bynner & Parsons, 2002; Kieselbach, 2003; Cusworth, 2009; Benjet, et al, 2012).

6.3.3 HADS-Anxiety and depression in NEET+ youth

The present study found that for HADS anxiety disorder 33% of NEET+ youth scored in the abnormal range compared to 19% of controls. This is close to an estimate by Benjet et al, (2012) who found that 34.3% of young people not in work or education reported elevated anxiety problems by using the World Mental Health Composite Diagnostic International Interview (cited in Benjet et al, 2012). Similarly, Thomas et al, (2005) found that psychological distress was prevalent in 35.5% of unemployed participants.

Concerning depression, The Princes Trust (2010) reported that 32% of NEET young people reported feeling depressed compared to 15% of controls. In the present study 33.3% of NEET+ young people reported borderline or abnormal symptoms for HADS depression compared to 19.5% for controls. Overall, HADS depression was the least prevalent disorder for NEET+ young people and controls. A reason for this can be found in studies by Hammarstrom and Janlert (2002) and Mossakowski (2009) who argued that disengagement from the labour force at a young age led to psychological and depressive symptoms developing in later adulthood.

In sum, although these studies report relatively similar findings, caution is advised, as the comparability of these studies is greatly limited, due to varied methods. Nevertheless, research is adamant in their findings that unemployment or social inactivity is detrimental to positive mental health and wellbeing (Schaufeli, 1997; Underlid, 1996; Sellstrom et al, 2011). The findings of the present study concur with this view, as the NEET+ sample fared significantly worse than controls.

6.3.4 Psychotic-Like experiences in NEET+

When risk of psychosis was assessed using the PROD, results indicated that at a cut off point of 3/12, over half of the NEET+ high risk sample was at risk of developing psychosis. In comparison, for controls 30.7% met the criteria for psychosis risk. As noted previously, PLEs have been identified as common in the general population however few of them result in psychosis (Verdoux & Van Os, 2002). Nonetheless, findings confirmed that NEET+ young people were at an increased risk of developing psychosis. In addition, 38% of NEET+ young people, reported general mental health symptoms, compared to 13.4% of controls. In sum, general mental health difficulties and PLEs were significantly more in NEET+ young people compared to controls ($p=.001$) and NEET+ young people had significantly more severe symptoms than controls ($p=.001$). These findings are in accordance with Banks and Jackson (1982) who found that unemployment resulted in increased mental health symptoms and psychological distress. In addition, Paul and Moser (2009) found that over several studies 16 to 34% of psychological symptoms in the unemployed reached clinical severity compared to those who were engaged in work. Although their findings were more applicable to middle aged populations, it appears to hold true for the present study, which suggests that NEET+ youth report mental health symptoms as more severe than non-NEET young people.

In sum, findings of the present study suggest that NEET+ youths have increased symptoms and severity for PLEs compared to controls. As a result, the symptoms reported by NEET+ youth are more likely to impinge on their everyday functioning. In light of this view, it is not surprising that NEET+ young people are unable to meet the demands placed on them by modern society (Chen, 2011). This often creates dissonance between the aspirations and expectations of young people (MacDonald, 2008; Finlay et al, 2010).

6.3.5 NEET+ youth willingness to seek help

GHSQ willingness to seek informal help was greater in both samples compared to willingness to seek formal help. However, the control sample on average was more likely to seek informal help. For controls 41.7% were likely to seek informal help compared to 21.4% of the NEET+ sample and 9.5% of NEET+ young people were likely to seek formal help in the next four weeks compared to just 4% of controls. The present study is consistent with other studies which suggest that barriers to help seeking exist, which prevent formal help seeking (Rickwood, et al, 2005; Walsh, et al, 2011). Young people in general seem unwilling to formally address mental health issues (Dixon, 2008).

Overall, there was no significant difference between controls and NEET+ young people for GHSQ total willingness to seek help. However, in line with Zachrisson et al, (2006) results suggest that young people with the worst symptoms do not get the necessary help. It appears that although there are increased difficulties in NEET+ young people, willingness to seek help is limited. Perhaps social disengagement and isolation reduces social support which is a facilitator of help seeking and resilience (Bartley, 1994; Scottish Executive Social Research, 2005; Osgood, et al, 2010). This may explain why NEET+ young people were significantly more willing to seek formal help for

emotional or behavioural difficulties compared to controls, while controls were significantly more willing to seek informal help for emotional or behavioural difficulties compared to the NEET+ sample. The greater willingness to seek informal help reported by controls may indicate greater social support.

6.4 Methodological limitations

There are a number of methodological limitations in the present study. Firstly, the sample sizes were modest and varied across measures; therefore these results should be interpreted with caution.

Despite the modest number of care leavers and NEET+ youth, significant differences were found for mental health difficulties when compared to a control sample. However, statistical analysis revealed that for sociodemographic information (age, ethnicity & gender) the control group were significantly different from the high risk groups. However, NEET+ youth did not differ significantly from controls for gender. This limits the interpretation of results as differences between the control group and vulnerable groups could be attributed to sociodemographic differences. This limits the comparability of the vulnerable groups to the control group, thus conclusions must be interpreted with caution. Although controls differed from the high risk samples on most sociodemographic variables, the school control sample was employed for the following reason; schools represented a more general population, those who go on to college or further education are a self-selected group. Thus, they are already a biased sample, as college students are expected to be more inspired or motivated, thus they may not be as representative of the general population. The present study does confirm the high prevalence rates of mental health difficulties in young people and highlights mental health difficulties in vulnerable young people. Future research

enlisting an age matched comparison group would be recommended to validate comparative findings. In addition, sociodemographic information is limited, for instance the length of time care leavers had been out of care was not attained. Thus, the interpretation of results is limited, as it is not known if the length of time out of care affected reports of mental health difficulties.

A further limitation is that multiple sources of information were not used. Previous research advises that multi-informants can add richness to self-report questionnaires, to provide a more accurate picture (Goodman, et al, 2004). However, this is mitigated as other reports suggest that additional informants tended to under report mental health difficulties (i.e. Cousins, et al, 2010). Thus, single informant self-report questionnaires were unlikely to jeopardise the internal validity of the study.

Finally, high risk young people were accessed from established social care youth organisations such as St Basils and The Princes Trust Fairbridge Programme. Thus, the sample included young people who may have received some kind of support. However, young people experiencing acute mental health difficulties may not utilise these services, but may be in contact with more specialist services. Such young people are less likely to have taken part in the study. This suggests that the proportion of high risk young people who may experience substantial mental health difficulties may be hard to reach and consequently the actual level of mental health need in care leavers and NEET+ young people may have been underestimated in the present study. Taken together such issues could have introduced recruitment bias, so these limitations should be taken into account when interpreting findings.

6.5 Implications

Despite the study limitations, the results of the present study point to peer difficulties as an area in need of substantial attention for NEET+ young people. Findings emphasise the importance of social networks and relationships in buffering the negative effects of social disadvantage and isolation.

In light of this finding, it is suggested that social, interpersonal skills, conflict resolution and interaction skills need to be cultivated in socially disengaged young people. This is especially important as NEET+ young people were less likely to seek informal help compared to controls.

Interestingly NEET+ young people did not differ significantly from controls for pro-social behaviour. What this suggests is that NEET+ young people rate themselves as having a positive attitude towards others (being pro-social), however perceive a negative attitude from others, hence NEET+ young people reported increased peer difficulties. Interventions focused on altering this perspective will be effective in building self-esteem and general wellbeing. Conduct difficulties were not specific to care leavers and NEET youth. However, high rates of conduct disorder have been found in LAC before entering care and whilst in care (Dimigen, 1999; Meltzer, et al, 2003; Teggart & Menary, 2010) compared to non care peers. However, the present study suggests that this difference was not present in care leavers. This indicates that young people in the general population may now experience more conduct problems.

Regarding care leaver's emotional difficulties were the most distressing of all the subscales with half the sample reporting abnormal scores. What this suggests is that care leavers need continued

emotional support. Care leavers need substantial after care counselling, emotional support and follow up. The notion of leaving care should change as care leavers should enter independence with a feeling of continued security, emotional and psychological support, which many non care children experience throughout their lives.

6.6 Summary

The present study aimed to investigate the proportion of mental health difficulties in high risk young people. Mental health research often overlooks high risk groups such as care leavers and NEET+ young people. What this study has done is provide detailed information on the mental health and wellbeing of care leavers and young people not in employment education or training.

Statistical analysis revealed the array of mental health difficulties that care leavers and NEET+ young people are confronted with. Emotional, behavioural, depression, anxiety and PLEs were increased in these two high risk groups compared to a control sample. What's more, willingness to seek professional help for these difficulties is subdued by poor mental health literacy, barriers to accessing services and stigma (Rickwood, et al, 2005; Burns & Rapee, 2006).

The present study has successfully highlighted the level of mental health difficulties in high risk young people. Future research can employ larger sample sizes and use diagnostic measures to supplement current findings. In addition future research should focus on harnessing peer skills in NEET+ young people and emotional difficulties in care leavers and young people in the general population.

7 MENTAL HEALTH LITERACY OF YOUNG PEOPLE

7.1 Introduction

This chapter describes an exploration of mental health literacy employing focus groups in three participant groups; school students, NEET+ status young people and care leavers. Focus groups are defined as ‘a group of individuals selected and assembled by researchers to discuss and comment on, from personal experience, the topic that is the subject of the research’ (Powell & Single, 1996, p.499).

The previous chapter provided an indication of the high level of mental health difficulties experienced by young people, particularly those with more vulnerable status. Mental health literacy can influence symptom recognition, symptom management and help seeking (Jorm, et al, 1997; Rickwood, et al, 2005) and the present chapter examines qualitative aspects of mental health literacy in young people.

7.2 Methodology

7.2.1 Aims and research questions

Mental Health Literacy has been defined as ‘knowledge and beliefs about mental disorders that aid recognition, management or prevention’ (Jorm, et al, 1997, p.182). The primary objective of the focus group was to examine any parallels between mental health difficulties in young people and their mental health knowledge and perceptions.

Research aims and questions are as follows;

1. To explore mental health literacy in three cohorts of young people i) those who are leaving school, ii) care leavers and iii) NEET+
2. To determine the words or images associated with mental illness, from the three categories of young people
3. What is their impression and perception of mental illness, treatments and services?

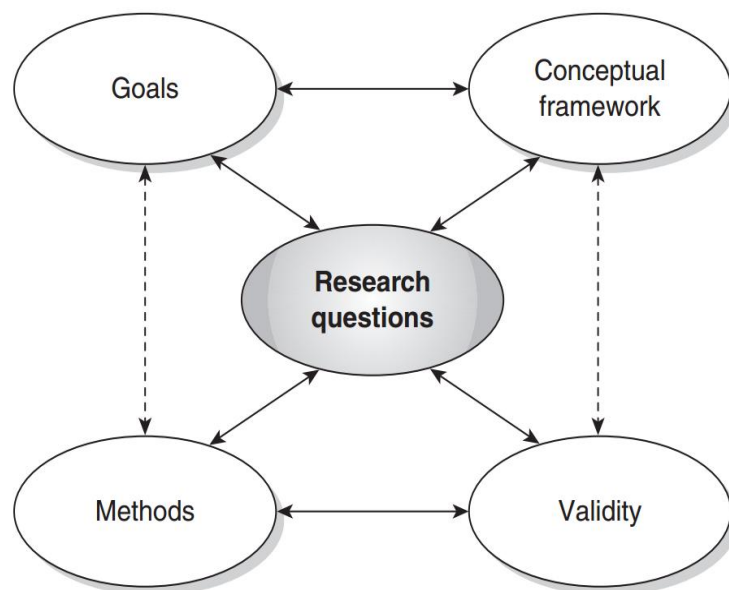
7.2.2 Focus group design and theoretical framework

Darbyshire et al, (2005, p.420) suggested that ‘while qualitative, survey and experimental studies are vital, they cannot by themselves provide all the information and insight...to help plan and provide appropriately responsive child and youth health services’.

Maxwell (1998; 2012) describes an interactive model for qualitative research which identifies four key components; the goal component requires a clear objective for undertaking the study, the conceptual framework requires identification of the problem, methods refer to the approach and techniques employed and validity of findings need to be considered (Maxwell, 1998; 2012).

According to Maxwell (1998; 2012) these components are interlinked to form a coherent study, thus, the focus group design for the present study was structured based on these components (Figure 7.1).

Figure 7.1 Interactive models for qualitative research design Maxwell (2012, p.5).



A qualitative exploratory method was undertaken for the present study, to assess mental health literacy and help seeking in young people. Calder (1977, p.355) defined the exploratory approach as ‘To generate scientific constructs and to validate them against everyday experience’. The author explains that an exploratory approach avoids issues of generalisability because the intent is to supplement scientific data. In terms of reliability Calder (1977) suggested that if the research is focused on generating explanations rather than representativeness, reliability is less of an issue. To maintain validity minimal input was offered by the researcher during discussions and participants were prompted to summarise their thoughts to facilitate interpretation of data (Calder, 1977). Powell and Single (1996, p.) stated that ‘one to 10 focus group sessions are generally sufficient for most studies’

7.3 Pilot focus groups

Firstly, pilot focus groups were conducted with college students to evaluate the effectiveness of the vignettes in initiating and encouraging discussions. The focus groups also helped to determine how young people would respond to the questions and the time it would actually take for young people to discuss the vignettes.

For the pilot study five focus groups were conducted which consisted of college students ages 17 to 20, who gave informed consent. Focus groups for the pilot study were conducted in groups of three, overall eight females and seven males took part. Table 7.1 presents information on ethnicity.

Table 7.1 Pilot focus group demographic information

| Ethnicity | College Students |
|------------------|-------------------------|
| White British | 8 |
| Afro Caribbean | 1 |
| Pakistani | 2 |
| Mixed | 1 |
| Somali | 1 |
| Asian | 2 |

7.4 Main focus groups design

As a result of conducting the pilot focus groups the design was altered to include elaborate techniques to encourage free responses (Darbyshire, et al, 2005), as young people were reserved when talking about mental illness. Darbyshire et al, (2005) employed multi-method elaborative techniques such as mapping to make focus groups more interactive, insightful and interesting. In the present study this approach was taken to encourage young people's verbal accounts about mental health vignettes (Darbyshire, et al, 2005) and young people were informed that they could write or illustrate their thoughts and feelings about mental health problems.

Depression and Schizophrenia vignettes from Jorm et al, (1997) were employed for the focus groups to explore mental health literacy and were presented to young people to read, after which they were asked a series of questions about the vignette. The questions were intended to ascertain participant's ability to recognise disorders; knowledge about risk factors and causes; knowledge of how to seek information; knowledge about professional help; attitudes that facilitate recognition and help seeking and knowledge about self-help intentions (Jorm, 2000). Young people were encouraged to discuss mental health problems based on hypothetical scenarios developed by Jorm et al, (1997). This approach encouraged contribution and minimised social desirability issues, which may have arisen if the questions were directly about participants.

Focus groups were conducted with year 11 pupils from inner city secondary schools in Birmingham UK, care leavers from Birmingham Local Authority care leaver service and NEET+ youth from The Princes Trust Fairbridge Programme. Each focus group contained between five and six participants and the duration was on average 30 minutes.

7.4.1 Demographics

Overall participants were ages 15 to 22 and within each focus group participants were homogeneous in setting, age range and gender. However, heterogeneity existed between the groups for gender and ethnicity (Table 7.2). Nonetheless, "A number of individuals may be very different in national origin, religious beliefs, political persuasion, and the like; but if they share a common identity relevant to the discussion..., a group can form" (Goldman 1962, p.62). Additionally, the variation between the groups may yield rich and less redundant information about the perceptions young people have about mental illness (Calder, 1977).

Table 7.2

Gender & Ethnicity for Main focus group

| | School pupils (n) | NEET+ (n) | Care Leavers (n) |
|------------------|-------------------|-----------|------------------|
| Gender | | | |
| Male | 2 | 3 | 0 |
| Female | 3 | 3 | 5 |
| Ethnicity | | | |
| White British | | 6 | 4 |
| Black African | | | |
| Pakistani | 4 | | |
| Mixed | | | 1 |
| Kosoven | 1 | | |

7.5 Focus group recruitment

The focus group sessions were conducted in Birmingham Local Authority drop in centers (care leavers), The Princes Trust Fairbridge Birmingham (NEET+) and school settings (see section 4.5).

School pupils were informed of the study by their Head of Year, six pupils volunteered to take part, however one did not attend. The focus group was held in the school premises with a facilitator.

Care leavers were recruited from St Basil's hostels for the focus group study. Managers informed support workers and care leavers about the study and five participants took part in the focus group. NEET+ youth were recruited from The Princes Trust Fairbridge Programme. They were informed of the study by development and outreach workers and six participants took part in focus groups conducted at The Princes Trust Fairbridge Birmingham Branch, with a facilitator present.

7.6 Consent and ethical considerations

Participants were informed of the purpose of the focus groups and were advised that data collected would be confidential and focus groups would be audio taped for transcription and analytical purposes. Participants were given information about the focus groups, provided with an information

sheet and given an opportunity to ask questions. Participants were required to complete a consent form before commencing the focus group. Participants displayed no signs of distress.

7.7 Focus group procedures

After introducing the research participants were informed of the structure of the focus group. Participants were then asked to read the depression vignette, after which, six semi-structured questions were asked. Participants were then asked to read a schizophrenia vignette; the same questions were asked and discussed. When both vignettes had been discussed, participants were asked to draw or write their impressions of mental health topics. This was to facilitate interaction and discussions. In addition, informal general questions were asked about mental health to allow flexibility and the inclusion of broader ideas.

7.8 Focus group data analysis

For qualitative interviews to ensure fidelity and validity thematic analysis methodology was employed as it allows flexibility, identifies similarities and differences in data and identifies unexpected insights (Braun & Clark, 2006). Guidelines given by Braun and Clark, (2006) on thematic analysis were closely followed;

1. Audio recordings were transcribed and screened for errors
2. Patterns were identified in the data
3. Coding and collating of latent and semantic content
4. Categories coded into themes
5. Review codes and refine themes
6. Detailed analysis of themes

7. Report the prevalence of themes via quotations.

Given the exploratory nature of the study, thematic analysis was deemed the most suitable method to employ. Inductive analysis allowed for themes to be identified based on the data collected rather than a pre existing theory (Braun & Clark, 2006), thus data analysis was more flexible as broader themes emerged. Semantic and latent thematic analysis was also used to identify surface meanings and underling ideas, assumptions and interpretations (Braun & Clark, 2006).

7.9 Focus group findings

While analysing the focus group transcriptions a number of narrative themes emerged, revealing the attitudes young people have towards mental illness. Discussions were supplemented with an elaborative sheet, which allowed participants to express their feelings about issues related to mental health. Observed themes are presented and differences among the three groups are discussed. A summary of findings are presented in Table 7.5 and Table 7.6.

7.9.1 Ability to recognize depression

When asked “What if anything is wrong with John?” (the person depicted in the depression vignette), some of the school students were able to identify the problem as depression. However a variety of other responses were given. Common themes were related to stress, work, being a teenager or different disorders altogether. Representative responses included:

“He could be under a lot of pressure...maybe his mind is on something else.” “Troubles...his got troubles something to do with work or personal troubles.” “Stress what teenagers boys go through.” “Some illness like Alzheimer’s.” “Anger management.” “Depressed his depressed, his depressed with his job” “something to stop you from not eating or not sleeping might”

When asked the same question care leavers generally suggested that the vignette described depression, however they also attributed symptoms to stress: *“stress means depression don’t it?”* Of all the issues mentioned the vignette was mostly recognized as depicting depression or stress: *“...It might just be at this stage of it being too much stress and it hasn’t developed in to depression yet.....Cause obviously if your stressed you don’t want to eat you’ve got too much going on.”*

For the NEET+ focus group, when young people were asked “What if anything do you think is wrong with John?” most participants recognized that something was wrong. However, participants were less detailed in their responses and there was some confusion as to what exactly the vignette was portraying. Several participants debated whether or not the vignette depicted paranoia:

“That’s not paranoia is it?” “Yeah because you won’t speak to no one will you.” “Paranoia is not about that, I’ve got paranoia and I can speak to loads of people it’s more like depression.” “Right well I am not saying the whole paranoid thing then.”

NEET+ young people were quite assertive when putting forward their views and at times were sarcastic:

“it’s somebody on a piece of paper, sorry paper did I hurt your feelings?” Other respondents felt the vignette showed someone with low self-esteem. *“No confidence.” “Either that or he is some ugly git that can’t stand himself.”* A few other respondents felt symptoms on the vignette may be due to bereavement. *“I know, he might not have got over someone who is dead.”*

One participant felt that the person illustrated in the vignette *“could be in a mental hospital,”* indicating a limited and extreme view of mental health treatments for depressive symptoms.

Generally young people across the focus groups recognized the problem as depression, however, some mentioned completely different disorders, such as *“anger management”* and *“Alzheimer’s”*. This suggests that young people were unable to differentiate between disorders and were unaware of the fundamental symptoms associated with certain disorders. At times young people also referred to the person illustrated in the vignette in negative terms revealing stigmatizing attitudes (Table 7.4).

7.9.2 Knowledge about risk factors and causes of depression

School pupils had difficulty identifying causes of the problem and were unable to elaborate. The majority of respondents felt *“work or relationships, family”* and *“personal life”* were causes. A respondent felt fatigue could cause Alzheimer’s: *“It makes sense, Alzheimer’s is mostly forgetting things...he seems to be feeling tired all the time and that could lead to it.”*

Risk factors mentioned were also related to lack of sleep: *“Probably because he doesn’t have his own time to do something, so he sleeps late, never gets enough sleep ends up waking up tired and it all happens again.”* *“Never know he could be on drugs in it that’s probably what’s making him go to work and have sleepless nights and stuff.”*

For the NEET+ focus group, respondents believed that the problem was caused by relationships:

“He could have broken up with his girlfriend and that sent him a bit.” or *“being bullied at work.”*

Other respondents attributed causes to *“mental disability”* and stress. *“Yeah he could be having a*

mental breakdown, just like having a lot of things going on it might be getting too much for him.”

“I know but it might not be depression it might just be stress.” “Might have gone all emo, might have turned into an emo.” People referred to as emo, are often stereotyped as wearing dark clothing and being emotionally distressed or out of the norm. Thus this was telling of the stigma attached to mental illness.

Causes mentioned by a couple of NEET+ young people included substance misuse:

“Could be smoking weed.” “He is either depressed or he is on drugs.”

Care leavers reported that being isolated was the cause of the problem in the vignette, *“Probably lonely because he’s got no company.” “Needs someone to talk to.”*

Overall, specific causes were difficult for young people to identify. Participants expressed frustration with the ambiguity of symptoms. However, young people attributed the cause of the mental health problem to substance misuse, emotional problems, loneliness and life stress. While professionals may concur with this view, young people neglected to mention the involvement of genetic factors. Most young people focused on external problems, life issues and interpersonal conflicts.

7.9.3 Knowledge and attitudes to help seeking for depression

Beliefs about causes can play a significant role in help seeking. For example school participants felt the vignette depicted a work related problem, thus would seek help at work:

“Cause I’m the one doing it, I’m the one going to work and then coming back late and then having less sleep then wake up again tired out knackered and stuff and then go to work again and then come home, I’d ask my boss to change it for me.” And if they were seeking help at school they would go to the *“school counselor.”*

When school students were asked how they would respond if they were in the same situation, many expressed a preference for informal help seeking::

“What I’d do is spend time with friends and family.” “See the doctors would be the last thing.”

“Just look at someone who has been in probably a similar situation or something.”

Some school participants also expressed barriers to help seeking:

“nobody wants to go tell them that there crazy or something, no one wants to admit that they have a mental health problem.... cause it’s like a label if you’ve got a mental health problem there’s something wrong with you so...nobody would understand.”

School participants also emphasized seeking help from *“someone they trust”* and *“someone who understands you.”* This suggests that young people have difficulty trusting professionals and confirms the view presented by (Munson, et al, 2011). Many participants did mention counseling and going to the doctors. However it seemed that they would prefer to deal with the problem themselves and at times neglected the necessity of getting professional help. A few young people also mentioned other pathways to seeking help such as:

“Yellow pages.” and *“Research, you could Google it try and find out what’s wrong.”*

In contrast to school students, NEET+ participants and care leavers expressed more willingness to seek formal help:

“Counseling and medication.” “Doctors.” “Counselors or therapy.” “I’d go seek medical advice.”

However a respondent from the NEET+ focus group described a barrier to help seeking:

“It depends though because when people do this therapy thing it cost money and they might not be able to afford it so they might just deal with it.”

Overall NEET+ participants and care leavers showed awareness of and intention to seek help from mental health professionals. In comparison school students were aware of such help, but emphasized a preference for informal help seeking from someone they know and trust. Barriers to help seeking such as cost and stigma were also mentioned. Broad (1999) found that young people were threatened by mental health services and had stigmatizing attitudes. This may explain the preference for informal help seeking.

7.9.4 Self help intentions for depression

Apart from informal and formal help seeking NEET+ young people and school students mentioned self help strategies to deal with the problem illustrated in the vignette such as:

“Forget about it,” “Go to sleep.” “I’d sort myself out; I’d see what’s going wrong and fix it.”

This indicated a lack of understanding about mental health; young people seem to think mental health is something that can be ignored or something that is within someone’s control. This creates

a barrier to help seeking. It appears that young people do not want to formally address mental health difficulties (Dixon, 2008).

7.9.5 Actions and attitudes towards depression

When school students, NEET+ young people and care leavers were asked about how family and friends would respond, most felt they would be supportive and try to find out what's wrong:

"She's my friend [referred to another participant] so I would talk to her about it and maybe ask try to find out what going wrong ask her family or friends if they have noticed a change....take her to the hospital or something find out if there's anything wrong."

"Give him a one to one talk...it looks like something is like trapped inside him so talk to him probably... so yeah" "I'd look up the symptoms." "Find out about it" or "Send him to a shrink." "Take them to the doctors." "Tell him not to stress."

A respondent from the NEET+ focus group said family or friends would:

"Sit him down talk to him and give him a cup of tea, a cup of tea makes someone happy" Perhaps indicating that young people may not understand the gravity of mental health difficulties.

Overall young people felt family and friends would be supportive and find out what was wrong by talking with the individual or signposting them to relevant services.

Table 7.3: Words Describing Depression

| Young people | Professionals |
|-----------------------|---------------------------|
| Craziness | Clinical depression |
| Weirdo | Major Depressive disorder |
| Cuckoo | Dysthymia |
| Emo | Bipolar depression |
| Not bothered/Given up | |
| Moody | |

Table 7.3 indicates that there is a gap between how young people talk about mental health compared to mental health professionals. One way to improve this may be to change the way young people talk about mental health problems, through education and improving their mental health literacy. This may also improve the relationship between young people, mental health professionals and mental health services.

7.9.6 Ability to recognize schizophrenia

When students were asked “What if anything do you think is wrong with Mary?” religion and cultural beliefs appeared to play a significant role in the ideas young people had about schizophrenia. Some school students from a Muslim background identified Mary’s symptoms as signs of possession:

“The devils inside her...walking around the bedroom talking to herself, that’s some mental issues no one does that on less their singing a song or something.”

“Exorcist, she’s possessed man.”

“She’s possessed by a demon.”

“that’s possessed man, why you going to whisper back to your parents.”

School students also attributed the narrative in the vignette to social problems with friends:

“She could be depressed and she hasn’t got someone to talk to so the only way is to talk to herself.”

“She’s probably lost her trust in all her friends that why she blocking them all off locking herself in her bedroom she thinks everyone is against her.”

“She’s under a lot of pressure and it’s obvious that she didn’t go to college and she’s living with her parents and her friend’s maybe they’ve gone to college, maybe she feels left out.”

“She probably feels alone.”

Just one participant from the NEET+ focus group mentioned schizophrenia and other respondents indicated uncertainty about the disorder:

“I ‘don’t know...can’t define it” ‘Is schizophrenia were like you’re a bit crazy (giggles), yeah you’re a bit crazy but...no schizophrenia is not when you’re crazy it’s just your paranoid and you think things are being said and stuff like that, and your just like mental all the time isn’t it?”

Other respondents from the NEET+ group misattributed symptoms represented on the vignette to different disorders or general life issues:

“She might have anorexia.” “She’s got lack of confidence in herself really if you think about it. Maybe she should have gone college, maybe that’s the reason she’s getting temporary jobs...and she needs to get herself sorted out.”

Most respondents labelled the problem as paranoia:

“Yeah but this is just our opinion, she’s just paranoid.” “Yeah yeah...just paranoid.” “Yeah but she’s paranoid, no confidence she’s got issues and bad issues” (laughs). “I think she’s been through something traumatic.” Mostly schizophrenia was associated with paranoia in the NEET+ group.

NEET+ young people had difficulty understanding why poor hygiene was a symptom, from all the symptoms in the narrative NEET+ respondents were most uncomfortable with hygiene issues:

*“She’s not hygienic.” “Hasn’t even had a bath like that’s a bit.” “She’s not had a bath...oh my god.” “I don’t know but the thing is though if she’s not had a bath, she’s going to obviously stink so people are going to be a bit bitchy about that.” “Bet that’s f***** up though, she’s like refusing to have a bath.” “She refused to have a shower my friend; literally had to drag her in to the shower.”*

Respondents from the school focus group expressed a similar frustration to NEET+ young people regarding hygiene: *“I don’t know how she hacks it not having a bath (laugh)...how can you not have a bath, probably got no shampoo left” (laughs). “But why would she not have a bath!”*

When care leavers were asked “What if anything is wrong with Mary?” most respondents said schizophrenia, however few were able to elaborate:

“More like Paranoid Schizophrenia though...because there’s different schizophrenia where you’re just very angry and there’s paranoid schizophrenia when you’re angry and scared.” “And you hear things, stuff like that.” “...not all there.”

Overall, young people expressed avoidant behaviour, negative language and being afraid of the person depicted in the schizophrenia vignette (Table 7.4):

“Spooky.” “Scary berry.” “I’d be a bit freaked out, won’t think oh shall I go and help them.” “They could just like lash out at you as well like or try and like twat you or something.”

Such behaviour may be due to stereotypes and general belief systems (Jorm, et al, 1997).

Furthermore, Gulliver et al, (2010) argued that fear and uncertainty were barriers to help seeking.

Schizophrenia was associated with possession, paranoia, social isolation, and self-esteem. Young people neglected to mention biological influences. Thus, young people demonstrated a limited knowledge of schizophrenia. The findings are consistent with Jorm, et al, (1997) who suggested that the public have a range of beliefs about mental health based on personal experience, culture and media, which create general beliefs systems. Below are representative quotes of belief systems young people expressed overall:

“She’s like Jean from Eastenders.” “I’ve lived with my brother and yeah he’s not all there.” “God, it’s for a reason in it, she needs a miracle to happen to her.” “Yeah, my brother escaped from one (mental hospital) and broke his hip...He’s really mentally ill my brother.

If people lack sufficient knowledge of mental health; they fall back on their general belief systems, which are sometimes flawed (Jorm, et al, 1997). Generally young people revealed negative, judgmental and stigmatising attitudes about schizophrenia, more so than for the depression vignette.

7.9.7 Knowledge about risk factors and causes of schizophrenia

Young people had difficulty stating the causes of schizophrenia. Many participants labelled the schizophrenia vignette as being due to lack of confidence, relationship difficulties, bullying and social isolation. Ironically for NEET+ young people causes were attributed to not being engaged:

*“She might think she’s worthless... she can’t keep a job, so she’s not going to get one, she can’t do this so she thinks f*** it, I might as well stay in the house and not do anything not even have a bath, and then because she not having social interaction for like six months she feels dead paranoid that people are watching her and she’ll start talking to herself.”*

“She’s got lack of confidence in herself really if you think about it. Maybe she should have gone college, maybe that’s the reason she’s getting temporary jobs...She needs to get herself sorted out.”

“She’s probably lost her trust in all her friends that’s why she is blocking them all off locking herself in her bedroom she thinks everyone is against her.” The school focus group also identified social disengagement as a cause for schizophrenia: *“Not having something to do...she’s probably at home all the time and she goes mad.” “Seeing the same faces every day inside your bedroom sees four walls and just goes to sleep.”*

“Unemployment.”

Care leavers had difficulty responding, and had mixed views in regards to causes. A few participants were unsure if depression caused schizophrenia:

“She might have been depressed over work so should work.” “So could depression cause schizophrenia?”

Another respondent felt having no one to talk to cause the problem:

“Her putting herself away from every one, she’s got no one to talk to.” One respondent stated that:
“I think it’s an illness.....but something can always trigger it off, cannabis that’s how Liam’s brother triggered it off.” A few respondents felt it *“can be what emotionally happened to you as a child.”*

Overall, participants described normal life stressors as causes of schizophrenia. Thus, there is an implication that if you make changes to your lifestyle you can resolve this problem on your own (see aforementioned quotes).

7.9.8 Knowledge and attitudes to help seeking for schizophrenia

When asked “What help do you think is available?” common themes arose from the three focus groups. For the Schizophrenia vignette when young people were asked what they would do in the given situation. The majority of respondents in all the focus groups said they would not know what to do unless they were in that situation:

“I don’t know she’s mad in it...”

“Yeah but you don’t know where your head would be, you can’t honestly say what you would do cause you don’t know where your head is like.”

“You don’t know what you’d do you’d be to scared...I’ don’t think you’d know what to do in any situation on less you face it.”

“I don’t think they realise that people are trying to help, you don’t know what’s going through their mind, they probably think what they are going through is normal, and then they’re just in a room can’t go out can’t do whatever they want it’s like no freedom, so they think professionals are against them, for all I know I could be talking to myself it’s all state of mind really.”

“...If your mental obviously you’re not going to know your mental.”

“You’ll just think everything is normal but be like a bunch of fruit cakes.”

“If I was Mary she wouldn’t know, so she wouldn’t do nothing.”

“She can’t talk to anyone so she won’t kind of know what the problem is.”

Overall participants said they would seek professional help form doctors or their GP. However the initial reaction for “What help do you think is available?” suggested a preference to seek informal help:

“I would talk to my best friend.”

“What I’d do is spend time with friends and family.”

“you feel more comfortable with family if you meet a new person you don’t straight away get on with them like if you had a mental problem or something you wouldn’t feel like you could trust them, like you’d think they would judge you or something like that even though they know what’s going on you’d just think it any way cause your paranoid.”

“See the doctors would be the last thing.”

“When I had depression I didn’t want to ask anybody for help because obviously they are people who don’t know you.”

“She could talk to someone about it like I don’t know she could talk to one of her parents or someone that she’s close to even if she locked everyone off there must be someone she can trust.”

7.9.9 Self help intentions for schizophrenia

Some participants also described self-help strategies, which often indicated a lack of understanding about schizophrenia. Young people suggested leisurely activities and socialising as self help strategies, they also expressed a snap out of it attitude and implied that symptoms were normal:

“She should start doing boxing take her anger out.”

“She needs to fix up.”

“Get out of it, go on holidays.”

“Why not listen to happy music... makes you happy.”

“Seek medical help, force yourself to go out.”

“Maybe she just needs to go out.”

“If she’s 17 she could come to Fairbridge were she meets people and all that don’t they...go on that residential...Cause you go on residential and that’s when you get to know everyone.”

“It’s good though because rather than messing about they just throw you into it then you’ve got no choice but to speak to people.”

“I would write a diary everyday about things I did that my parents know I can’t remember.” “It’s not as bad as it looks really it’s not like she’s cutting up her arms or something like that or hurting herself or anyone, she’s just not eating and having a bath, like normal people...there is something bugging her.”

“Take her bedroom key off her; she can’t lock herself in her room (laugh) just in case it comes to something serious.”

Young people certainly require more information in this area. Moreover, Zwaanswijk et al, (2003) argued that young people wait until symptoms are severe before acquiring formal help. In the present study, it appears that young people are unable to accurately assess risk. This is because the self help strategies mentioned by respondents showed that the schizophrenia vignette was not perceived as severe.

Another overriding theme from all the groups was that young people tended to have negative views about available treatments or felt treatment was not helpful. One young person said:

“I would commit suicide... if I was in that situation I’d probably do something like that rather than suffering every day I’d get it over and done with.”

“Mental home.”

“Foster home.” “Padded room...like 24 hr care for like a few months to get her life sorted make sure like she feels like worthy to live like not just exist”

“I think a mental home though; will make them even more mental to be fair.”

“Yeah, my brother escaped from one and broke his hip...He’s really mentally ill my brother.”

“I’d call it a mad house”

“Nah cause I’m depressed anyway and I didn’t want to go to the doctors because I know the first thing they offer me is medication. Yeah...and I don’t want that, I don’t want to be that drugged up that I forget days with my baby.”

“And like you have to depend on a drug to get you going through the day.”

Negative views and experiences such as these have been identified as barriers to seeking professional help (Rickwood, et al, 2005). It appears that young people see available treatment for mental health problems as bad for their health. Religion was also mentioned as a source of help by some young people from the school focus group:

“I think most people would turn to Islamic teachings...tell them to pray, pray for them, maybe bring an Imam to the house to pray” “Try and encourage her to connect more with her religion.”

7.9.10 Actions and attitudes towards schizophrenia

When all young people were asked how others would react to the person depicted in the vignette, a few did mention getting medical help:

“No because you can get medication from the doctors, if you go to the doctors you can get medication.”

However respondents revealed negative views towards the schizophrenia vignette, such as fear and avoidance. Also young people implied that family or friends would be dismissive or lack understanding. Representative quotes about attitudes towards schizophrenia included:

“People like that do actually scare me.”

“Sometimes you get scared don’t you if your kid might have it you don’t want to really admit to it sometimes you think everything is alright ...they’ll probably think it’s just a phase cause she’s 17 and everything like a teenager.”

“You’d want to avoid somebody like that.”

“If I see someone like that down the street I’d walk on the other side.”

“Get a slipper and whack her (laughter). My mum I don’t know, I know she would take my bedroom key of me though she wouldn’t let her stay in the bedroom all day, the funny thing is it depends how the family go on in it cause I’d probably say to my sister what the heck go and have a shower or something you stink or something in it.”

Table 7.4: Words describing schizophrenia

| Young people | Professionals |
|------------------|----------------------------|
| Schiz/Schizo | Schizophrenia |
| Mad/Mad head | |
| Possessed /Demon | Schizoaffective Disorder |
| Crazy | |
| Paranoid | Catatonic Schizophrenia |
| Mental | |
| Trapped | Paranoid schizophrenia |
| Fruit cake | Disorganized Schizophrenia |

7.9.11 Elaborative data: young people's notes and illustrations

Some young people expressed further views and opinions by writing on sheets of paper or drawing their thoughts about mental illness. The notes from NEET+ young people for depression showed that young people viewed depression in relation to loneliness, suicidal thoughts and self harming, while other young people attributed it to feeling sad. For schizophrenia half of all the participants noted that they did not know anything about it, some respondents illustrated this by writing a question mark near the word schizophrenia. For those who made notes on schizophrenia, their notes included negative words such as: Psycho or Possession. A couple of young people noted '*happy pills*' and taking more medication as part of depression and schizophrenia. Young people also noted being embarrassed or being in denial when talking to professionals and felt professionals were intrusive.

School students drew their thoughts about mental health, depression and schizophrenia (Figure 7.2, 7.3 & 7.4). Drawings clearly showed that young people hold, negative and extreme views about mental health problems, reinforcing focus group findings and drawings depicted violence, torment and death. If this is how young people perceive mental health disorder, it is likely that they believe others view mental disorder in the same way. If this is the case, young people may be less likely to

seek help, to avoid being judged in this way. This is consistent with Rothi and Leavey (2006) they found that how young people perceive their mental health needs will have a tremendous effect on their help seeking behaviour.

Figure 7.2 Thoughts and feelings about mental illness



Figure 7.3 Thoughts and feelings about depression



Figure 7.4 Thoughts and feelings about schizophrenia



Table 7.5: Summary of key findings about mental health literacy (MHL) for depression (all groups)

| MHL | Findings |
|---|---|
| Ability to recognise disorders | Although some young people recognised the disorder as depression, they were generally uncertain and suggested other disorders as being the problem. |
| Knowledge about risk factors & causes | This was limited to environmental issues such as stress or work and social pressures. Biological or psychological factors were not mentioned. |
| Knowledge and attitudes to help seeking | School students were more likely to mention seeking informal help, while care leavers and NEET+ respondents mentioned more formal help seeking. |
| Self help intentions Actions and attitudes | Passive, not actively doing anything to tackle problem. Families and friends seen as providing support and trying to find out what's wrong. |
| Lexicon | Young people did use some negative stigmatising words when referring to the vignette. |

Table 7.6: Summary of key findings about mental health literacy (MHL) for schizophrenia (all groups)

| MHL | Findings |
|---|--|
| Ability to recognise disorders | Limited knowledge about schizophrenia and extreme views. Those from religious backgrounds described the vignette as depicting demon possession. Young people expressed fear and schizophrenia was mainly associated with paranoia. |
| Knowledge about risk factors & causes | Causes were associated with problems with employment, self-esteem, drugs and not having friends to talk to. Biological or Hereditary influences were not mentioned as risk factors. |
| Knowledge and attitudes to help seeking | Pathways to help seeking unelaborated, little knowledge about treatments. Young people unfamiliar or untrusting of mental health treatments. Mentioned more intention to seek informal help. |
| Self help intentions | Young people did not recognise symptoms as serious: "Why not listen to happy music..." Thus self help strategies likely to be ineffective. Indicated a poor understanding of mental health needs. |
| Actions and attitudes | For schizophrenia families were seen as less supportive and more dismissive: "it's just a phase." |
| Lexicon | Negative words and stigmatising words used. Thus young people may want may to disassociate themselves from issues surrounding mental illness. |

7.10 Conclusion

Focus groups provided insight into the way some school students, care leavers and NEET+ young people in Birmingham UK think about mental health. These groups are not representative of the general population, however the focus groups demonstrate that mental health literacy in young people can be improved.

Young people lacked knowledge about treatments, which resulted in a rather bleak view of recovery and mental health outcomes. Professional help was not always preferred and was often negatively perceived due to negative experiences or beliefs. There appears to be stigma attached to mental health services, which discourages young people from professional help seeking. The words used by young people during the focus group suggested that negative, insensitive and stigmatizing language were associated with mental ill-health, confirming that there is still an incredible amount of stigma associated with mental illness (Shook, 2011). Some student participants saw mental illness as spiritual rather than a physical ailment, which could hinder professional help seeking. Interventions and campaigns would need to focus on reducing the stigma young people have about mental health services and educating them about available help and risk factors. Previous research has shown that mental health difficulties begin in adolescence; therefore it is important that young people and want to seek formal help and know how and when to get it.

Young people were sometimes unable to differentiate normal life issues from mental health difficulties. At times young people also showed confusion about different disorders and were unable to differentiate them. Consequently, young people may require more education on awareness of mental health symptom recognition. In addition young people were at times amused or saw mental health difficulties as normal, suggesting inaccurate risk assessment.

The focus groups did demonstrate common themes, however for care leavers and NEET+ focus groups, participants were more likely to have had direct or indirect experiences with mental illness. Essentially better mental health literacy may result in better symptom management, better communication with mental health professionals and increased help seeking, particularly for vulnerable groups.

These findings converge with findings from previous research, which suggest that mental health literacy in young people is inadequate (Jorm, et al, 1997; Yung, et al, 2003; Burns & Rapee, 2006).

7.11 Recommendations

1. Mental health interventions should focus on making services more attractive and less intimidating by correcting belief systems about mental health services.

Generally participants did not speak positively about mental health services, but were more interested in getting help from friends and family or engaging in self help. More importantly, interventions should focus on balancing the pessimistic and grim outlook young people have about mental illness.

2. Misconceptions about treatments need to be addressed

Young people need to understand available treatments (i.e. side effects, efficacy) so that they can make informed choices. Young people clearly share different views compared to mental health professionals. This is likely to hinder the implementation of clinical intervention and help seeking (Jorm, et al, 1997).

3. Causes of mental health

More information about biological, physiological and environmental triggers of mental illness can help young people properly evaluate themselves and others if something is wrong.

Explanatory Models

Young people did have some knowledge about disorders. However young people tended to misattribute symptoms to entirely different disorders. I.e. anorexia and bulimia were mentioned as being the problem for the schizophrenia vignette. On the other hand depression was compared to Alzheimer's and depression was used synonymously with stress. It is important, therefore, that young people understand the differences between disorders and their symptoms.

4. Improve young people's mental health lexicon

Informing and educating young people with the right information, can improve how they talk about mental health. Positive information about mental health services will help change the negative views young people have about mental illness and alter how they vocalise these views for the better.

5. Understanding what is normal and what is not

Young people need to be able to assess if a situation is due to a temporary issue, or if it requires medical support.

6. Awareness of religious beliefs

Formal mental health services need to educate and demonstrate the efficacy of medical treatment to religious groups, and not alienate them. Treatment needs to be seen as relevant and helpful to these groups.

8. EVALUATING A PILOT MENTAL HEALTH TRAINING FOR LAC/CARE LEAVERS STAFF

8.1 Introduction

As mentioned previously young people are often reluctant to seek professional help for mental health difficulties, and staff who work with young people in care or leaving care get very little mental health training (Department of Health, 1992, p.116, cited in Hatfield et al, 1996, p.129). Therefore it is necessary to ensure staff that work with vulnerable young people have sufficient mental health knowledge to encourage young people to seek help from the relevant services (Mount, et al, 2004). This chapter describes the planning and testing of a two day pilot mental health training course conducted by staff from Birmingham and Solihull Mental Health Foundation Trust. The aim of the training course was to improve mental health literacy in Birmingham local authority staff and subsequently improve mental health service utilisation.

8.2 Rationale

Chapter 2 and 3 of the thesis has documented the high prevalence rates of mental health difficulties in NEET young people and care leavers particularly the gap between prevalence rates and service utilization (e.g. Ravens-Sieberer, 2008). Additional research has highlighted that Local Authority service providers such as social workers play a distinct role in ensuring mental health service provision and utilization (Aviram, 2002; Sedgewick & Blackwell, 2007). Thus investing in local authority staff through mental health training may help to facilitate the wellbeing of LAC and care leavers by improving ‘intuitive judgment’ in staff (Department of Health, 2004, cited in Sedgewick & Blackwell, 2007; Mount, et al, 2004, p.365). To the author’s knowledge, no previous reports have documented interventions testing the benefits of mental health training for staff working with

young people in care or leaving care. This is a concern, as studies have described a need for improvement in the mental health knowledge of service providers, with staff assessments of youth mental health problems found to be inaccurate (Stiffman, et al, 2000). Improving mental health knowledge for local authority staff may help to improve the recognition of early psychosis and referrals to relevant services (Cheng, et al, 2013), potentially minimizing treatment delay and increasing service utilization. The Scandinavian TIPS study found that targeted community education increased referrals and improved pathways to care which led to early detection of psychosis (Johannessen, et al, 2001), although the TIPS study was not based on local authority staff, it did suggest that health education can improve appropriate access to services for psychosis. Similarly, Kitchener & Jorm, (2002) found that a mental health training course proved useful in improving mental health literacy in the general public. Training staff who work with vulnerable groups such as LAC could enable them to intervene early by signposting individuals to appropriate services. This constitutes a targeted intervention, which was described by Giesen, et al, (2007) as effective.

Another issue raised by Rickwood et al, (2005) related to barriers to help seeking in young people. An inability for young people to express their symptoms and negative experiences with services were mentioned as a barrier to help seeking. If this is the case those who work with vulnerable young people have a significant role to play in promoting services and being informed and capable in relation to awareness of potential problems. In addition, Gulliver et al, (2010) found that difficulty accessing services and the behaviour and attitudes of service providers were barriers to help seeking. With this in mind mental health training for service providers is warranted to ensure they exhibit a positive attitude towards young people with mental health difficulties and can provide signposting and access to appropriate services.

The training was commissioned by the Local Authority in liaison with the clinical youth programme at Birmingham and Solihull Mental Health Foundation Trust. The Trust service-user led youth board was integral in planning the training programme. The training involved both knowledge based (educational) and contact based (service user experiences/case studies) methods and focused on modules covering youth mental health; attachment and resilience; youth engagement; common mental health disorders; risk and self-harm behaviours and the importance of mental health knowledge when working with such vulnerable groups. The content of the training was informed by findings from the present study.

The training evaluation determined how effective the course was in improving staff knowledge and potentially their efficacy in working with vulnerable young people emerging from statutory care systems who may be at a high-risk of experiencing mental ill-health. Such training has an integral function in youth mental health service development. Sebuliba and Vostanis (2001) report that as the mental health sector continues to expand and engage in joined up working, there will be a greater need for regular training particularly for targeted mental health training programmes.

8.3 The LAC mental health pilot training programme

Is a two day course aimed at staff working in Children in Care teams and 18+ Care Leavers in Birmingham City Council. The course aimed to highlight the significance of youth mental health and implications for working with LAC. The course aimed to enhance skills knowledge and values concerning mental health. The training contained modularised interactive sections and integrated case studies, role play and video clips. The content of the training package included:

- Young people and mental health
- Attachment and Resilience
- Working in crisis- self harm, suicide etc.
- Building on resilience- basic good health practice.
- Engagement and trust.

A range of experiential exercises were integrated into the training to provide contextual learning for participants.

8.4 Methodology

The evaluation comprised of both qualitative and quantitative methods in order to ascertain the effectiveness of the training.

8.4.1 Design

A mixed methods design was used. Data was collected from looked after children and care leavers staff (LACS) using questionnaires, vignettes and semi structured interviews to evaluate the two day mental health training. Gender was randomly assigned to the vignettes for this phase of the study, as a result, Mary represented depression and John represented schizophrenia.

Pre and post-training evaluations were conducted by administering one self-report questionnaire before the training (pre-test) and again after the training (post-test). Subsamples of participants were randomly selected for telephone interviews about the mental health training 8-12 weeks later.

8.4.2 Ethics and consent

Ethical approval was gained from The University of Birmingham to conduct this research.

Opt- in written consent was required for participants to take part in the study. Participants were informed that the information they provided would be kept confidential and were told that participation was voluntary. Participants were also informed that they could withdraw at any time during the training evaluation and interviews.

8.4.3 Sample

The evaluated training workshops involved 41 aftercare staff, social workers and children in care teams in Birmingham City Local Authority. From all participants, 30 members of staff gave consent and agreed to complete the pre and post evaluation questionnaire. Of the 30 participants that took part in the pre and post evaluation 12 were randomly selected for follow-up telephone interviews related to the training.

8.4.4 Procedure

Staff from the Birmingham City Local Authority who worked with children in care and leaving care teams were invited to take part in the two day training workshop facilitated by the clinical youth programme. Participants were informed of the study and required to give consent to take part in the pre and post evaluation and interviews at the beginning of each training session. Those who consented to take part in the evaluation study completed a pre-training questionnaire prior to participation in the course and were asked to complete a post-training evaluation on completion of

the two day course. Questionnaires required approximately 30 minutes to complete. Follow up semi-structured telephone interviews with 12 participants who had received training were conducted approximately 8 to 12 weeks after participants had completed the course. In total 12 telephone interviews lasting on average 30 minutes were completed.

8.5 Measures

The pre-test evaluation questionnaire included all the measures listed below. The post-training evaluation included the same measures, with the omission of socio-demographic information:

1. Sociodemographic information included; age, gender, ethnicity, occupation and contact information.
2. Vignettes of young people describing symptoms of either depression or schizophrenia (Jorm, et al, 1997) were used to ascertain the mental health literacy of local authority staff pre and post-training. The vignettes consisted of two scenarios, the first scenario describing symptoms of depression and the second scenario symptoms of schizophrenia. The depression and schizophrenia vignette met ICD-10 and DSM-IV criteria for major depressive disorder or schizophrenia (Jorm, et al, 1997). The vignette descriptions were slightly modified to reflect the younger age focus of training (from 30 to 24 in the original vignettes to, 17 for depression and 16 for the schizophrenia vignette). In addition both the original vignettes referred to a male character; however one was adjusted to reflect a female character for the purposes of local authority training. These modifications better reflected the young people staff worked with and had on their caseload. Actual alterations to the vignette are shown below:

Original vignette for depression:

John is 30 years old. He has been feeling unusually sad and miserable for the last few weeks. Even though he is tired all the time, he has trouble sleeping nearly every night. John doesn't feel like eating and has lost weight. He can't keep his mind on his work and puts off making decisions. Even day-to-day tasks seem too much for him. This has come to the attention of his boss, who is concerned about John's lowered productivity.

Modified vignette for depression:

Mary is a 17 year old who has been feeling unusually sad and miserable for the last few weeks. She is tired all the time; she has trouble sleeping nearly every night. Mary doesn't feel like eating and has lost weight. She can't keep her mind on her studies and she puts off making any decisions. Even day-to-day tasks seem too much for her. This has come to the attention of Mary's tutor, who is concerned about her absence at college.

Original vignette for schizophrenia:

John is 24 and lives at home with his parents. He has had a few temporary jobs since finishing school but is now unemployed. Over the last six months he has stopped seeing his friends and has begun locking himself in his bedroom and refusing to eat with the family or to have a bath. His parents also hear him walking about his bedroom at night while they are in bed. Even though they know he is alone, they have heard him shouting and arguing as if someone else is there. When they try to encourage him to do more things, he whispers that he won't leave home because he is being

spied upon by the neighbour. They realise he is not taking drugs because he never sees anyone or goes anywhere.

Modified vignette for schizophrenia:

John is a 16 year old who lives with his auntie. He has had a few temporary jobs since finishing school but is now unemployed. Over the last six months he has stopped seeing his friends and begun locking himself in his bedroom and refusing to eat with the family or to have a bath. His auntie and other members of the household hear him walking about in his bedroom at night while they are in bed. Even though they know he is alone, they have heard him shouting and arguing as if someone else is there. When they try to encourage him to do more things, he whispers that he won't leave home because he is being spied upon by the neighbour. They realize he is not taking drugs because he never sees anyone or goes anywhere.

The scenarios were intended to evaluate mental health knowledge. Specifically, symptom recognition, knowledge of available help and actions they would take. These vignettes were presented in turn with a series of open ended questions taken from Jorm et al, (1997) and Morawska et al, (2013). Participants were able to write their responses in spaces provided on the evaluation forms. Minor alterations were made to tailor the questions to the study sample:

- a. What, if anything, do you think is wrong with Mary?
- b. How do you think Mary could be best helped?
- c. Imagine Mary is a young person you know. You want to help her. What would you do?

- d. How confident would you currently feel in helping Mary?
- e. If Mary requires treatment indicate which type of treatment is helpful or harmful

The first three questions (a, b & c) were adapted from the Jorm et al, (1997) vignettes. These questions were designed to find out if participants identified a problem and their thoughts about seeking help. The additional questions were adapted from Morawska et al, (2013) and aimed to find out how comfortable participants felt regarding dealing with mental health issues, knowledge and perceptions in relation to treatments.

3. Pre and post-evaluation questions

Mental Health First Aid (MHFA) is a 12 hour training course developed by Kitchener and Jorm, (2002, 2008) to inform people in the general population about symptoms of mental health difficulties. MHFA focuses on training the general public to improve mental health literacy including information about anxiety, depression and psychosis, as these disorders are relevant to the present study and MHFA is well established in several countries and has been well evaluated (Robson & Bostock, 2008), thus general pre and post-evaluation questions in this study were adapted from MHFA evaluation questionnaires (Robson & Bostock, 2008). In total the questionnaire contained 22 questions (Appendix 8).

4. The Depression Stigma Scale

The Depression Stigma Scale was developed by Griffiths et al, 2004. The scale contains two subscales, the Personal Stigma Scale and the Perceived Stigma Scale (Morawska, et al, 2013).

The scale was used to ascertain stigmatising attitudes of participants. Items on the questionnaire were formulated by identifying frequent themes relating to depression and stigma using online search engines (Griffiths, et al, 2004). Principal component analysis (PCA) revealed personal stigma and perceived stigma as the main components of participant's responses and for the personal and perceived stigma subscales Cronbachs alpha was 0.77 and 0.82 respectively, showing acceptable internal reliability, PCA also suggested that the scale had sufficient validity (Griffiths, et al, 2004; Griffiths, et al, 2008). Participants were required to indicate the extent to which they agreed with particular statements about the person described in the vignette. Using a five point Likert scale participants rated their personal thoughts and thoughts of other people (1 =strongly agree, 2 = agree, 3 = neither agree nor disagree, 4 = disagree, 5 = strongly disagree). The present study asked participants to rate their agreement with seven statements on the personal and perceived stigma scale relating to the depression and schizophrenia vignette. Total scores were calculated for each scale, with higher scores indicating increased stigma.

5. Follow-up telephone interviews

A telephone interview was selected to evaluate the benefits of the training. Telephone interviews can be less intimidating than face to face, and can reduce interviewer effects (Sturges & Hanrahan, 2004). When face to face interviews were compared to telephone interviews Marcus & Crane, (1986, p.113) found 'marked similarities in the quantity, nature, and depth of response'. In addition Burnard (1994) argued that telephone interviews are useful for collecting a wide range of information, both qualitative and quantitative. Participants had busy schedules and were often out of office for client visits but since workers were allocated mobile phones, telephone interviews were convenient, cost effective and time effective (Burnard, 1994). The interviews were also helpful in maintaining anonymity and privacy (Sturges & Hanrahan, 2004). In sum telephone interviews have

been described as ‘an efficient, reliable, and valid form of data collection’ (Musselwhite, et al, 2007, p.1069).

Semi-structured telephone interviews were used to assess participant’s thoughts on the training and if participation in the training impacted their work with children in care and care leavers. As recommended by Burnard (1994) a conversational style was used in order to help participants feel comfortable. Introductions and pre interview calls also helped build rapport and prepare participants for the telephone interviews and cultivate ‘naturalness’ (Irvine, et al, 2013, p.89), which has been identified as a valuable tool for increasing interaction and discussion (Irvine, et al, 2013).

The interview schedule for the present study included questions formulated from the Mental Health First Aid Evaluation Studies (Robson & Bostock, 2008; Morawska, et al, 2013). These questions were felt to be appropriate as the present evaluation study had similar objectives to MHFA evaluation studies. Open ended questions were used to encourage responses. The interview asked participants if they had worked with any young person with mental health difficulties since the training and how they handled it. Participants were rated on their confidence in regards to working with young people’s mental health difficulties. If participants had not worked with young people experiencing mental health difficulties, questions were asked about how they would deal with the situation if confronted with it. Participants were asked if the training was useful and if they noticed any changes to their practices since the training. Interviews were audio recorded for transcription purposes.

8.6 Data Analysis

Quantitative analysis was undertaken for the pre and post-evaluation questionnaire. Statistical Programme for Social Sciences (SPSS) version 19 was employed to compute non parametric tests. The significance level was set at $p < 0.05$. Free responses were coded according to the type of response given by participants. The coding categories used in the present study were taken from Minas et al, (2009) to ensure a systematic approach was used. Responses were coded as follows; 0=no response/insufficient, 1=basic response, 2= detailed response. For telephone interviews the data was coded and grouped into common themes which were extracted in order to evaluate training feedback.

9 QUANTITATIVE AND QUALITATIVE RESULTS FOR LOOKED AFTER CHILDREN STAFF (LACS) TRAINING EVALUATION

9.1 Introduction

This chapter presents the results of the pre and post questionnaire which was administered to LACS before and after a pilot mental health training course. The results are presented in two sections; the first provides quantitative findings regarding the impact of the mental health training course in terms of improving staff knowledge about youth mental illness and the second section provides qualitative findings from telephone interviews, to further evaluate the training course and explain quantitative findings.

9.2 Preliminary data analysis

Preliminary data analysis was performed in order to ascertain if data met the assumptions of parametric statistical tests. The normality of distribution for LACS pre and post questionnaire scores were assessed using the Shapiro-Wilk Test. This is because the 'Shapiro-Wilk has been found to reach 'sufficient power levels with 20 and larger sample sizes' (Mendes & Pala, 2003, p.137). Findings indicated that the majority of data was not normally distributed and non parametric analysis was undertaken. These included the Wilcoxon statistical test and the McNemar test for dichotomous variables.

9.2.1 Missing values

Prior to data analysis data cleansing was undertaken. Missing values, on the pre-test questionnaire were imputed with the modal value, this constituted 2.6% of values. Missing values that occurred on the post evaluation questionnaire were substituted for the pre-test scores, thus improvement between the pre and post questionnaire was not assumed (Kitchner & Jorm, 2002)

9.3 Demographic characteristics of the sample

Most participants were 40-49 years old (age range 20-59) and twice as many females compared to males took part in the study. Demographic information is shown in table 9.1.

Table 9.1
Socio demographics for LACS pre and post evaluation questionnaire

| Characteristic | LACS | |
|----------------------------------|------|------|
| | N | % |
| *Age | | |
| 20-29 | 1 | 3.3 |
| 30-39 | 7 | 23.3 |
| 40-49 | 12 | 40.0 |
| 50-59 | 7 | 23.3 |
| Gender | | |
| Male | 10 | 66.7 |
| Female | 20 | 33.3 |
| **Ethnicity | | |
| White British | 8 | 26.7 |
| Mixed White & Black Caribbean | 2 | 6.7 |
| Asian/Asian British Indian | 2 | 6.7 |
| Black or Black British Caribbean | 16 | 53.3 |

*3 responses missing

**2 responses missing

9.4 Mental health knowledge, confidence and feelings about mental health and treatment type in LACS.

Tables 9.2, 9.3 & 9.4 present the differences in pre and post-test ratings for LACS. Table 9.2 clearly shows that more LACS rated themselves as having quite an intense knowledge of mental health in the post-test (40%) compared to the pre-test (13.3%). In addition LACSs were almost five times more likely to rate their knowledge of mental health in young people as good in the post-test (65.5%) compared to the pre-test (13.8%).

Table 9.3 indicates that LACS reported having greater confidence in understanding depression and schizophrenia after the training. For depression, LACS rated themselves as having quite a lot more confidence in the post-test (50%) compared to the pre-test (13.3%). For schizophrenia 13.8% of staff rated themselves as not at all confident compared to 0% on the post-test.

Table 9.2
Proportion of LACS general knowledge & knowledge about young people's ratings

| Ratings | LACS | |
|--|--------------|---------------|
| | Pre-Test (%) | Post-Test (%) |
| General Mental Health Knowledge | | |
| A little bit | 46.7 | 10.0 |
| Moderate | 36.7 | 46.7 |
| Quite Intensely | 13.3 | 40.0 |
| Very Intensely | 3.3 | 3.3 |
| Knowledge of vulnerable youth | | |
| Poor | 13.8 | 3.4 |
| Limited | 72.4 | 27.6 |
| Good | 13.8 | 65.5 |

Table 9.3
Proportion of LACS confidence ratings when dealing with disorders in vignettes

| Ratings | Depression Vignette | | Schizophrenia Vignette | |
|-------------|---------------------|---------------|------------------------|---------------|
| | Pre-Test (%) | Post-Test (%) | Pre-Test (%) | Post-Test (%) |
| Not at all | 0 | 0 | 13.8 | 0 |
| A little | 26.7 | 0 | 17.2 | 10.3 |
| Moderate | 46.7 | 26.7 | 37.9 | 41.4 |
| Quite a lot | 13.3 | 50.0 | 13.8 | 27.6 |
| Extremely | 13.3 | 23.0 | 17.2 | 20.7 |

Table 9.4
Proportion of LACS feelings about disorders in the vignettes

| Ratings (feelings) | Depression Vignette | | Schizophrenia Vignette | |
|--------------------|---------------------|---------------|------------------------|---------------|
| | Pre-Test (%) | Post-Test (%) | Pre-Test (%) | Post-Test (%) |
| Anxious | | | | |
| Not at all | 27.6 | 33.3 | 10.0 | 16.7 |
| A little | 24.1 | 23.3 | 23.3 | 13.3 |
| Moderate | 17.2 | 10.0 | 13.3 | 26.7 |
| Quite a lot | 24.1 | 20.0 | 23.3 | 20.0 |
| Extremely | 6.9 | 13.3 | 30.0 | 23.3 |
| Uneasy | | | | |
| Not at all | 37.9 | 43.3 | 6.7 | 16.7 |
| A little | 20.7 | 16.7 | 30.0 | 16.7 |
| Moderate | 10.3 | 13.3 | 10.0 | 26.7 |
| Quite a lot | 17.2 | 20.0 | 23.3 | 23.3 |
| Extremely | 13.8 | 6.7 | 30.0 | 16.7 |
| Desire to help | | | | |
| Not at all | - | - | 63.3 | 56.7 |
| A little | - | - | 26.7 | 96.7 |
| Moderate | 10.0 | 6.7 | 10.0 | 100.0 |
| Quite a lot | 50.0 | 36.7 | - | - |
| Extremely | 36.7 | 56.7 | - | - |
| Sympathy | | | | |
| Not at all | - | - | 50.0 | 30.0 |
| A little | 3.3 | 6.7 | 23.3 | 40.0 |
| Moderate | 33.3 | 16.7 | 10.0 | 13.3 |
| Quite a lot | 26.7 | 40.0 | 13.3 | 10.0 |
| Extremely | 33.3 | 30.0 | 3.3 | 6.7 |
| Anger | | | | |
| Not at all | 82.8 | 76.7 | 76.7 | 83.3 |
| A little | 6.9 | 6.7 | 10.0 | 3.3 |
| Moderate | 3.4 | 10.0 | - | 6.7 |
| Quite a lot | 3.4 | 3.3 | 10.0 | 6.7 |
| Extremely | 3.4 | 3.3 | 3.3 | - |
| Irritation | | | | |
| Not at all | 58.6 | 76.7 | 70.0 | 80.0 |
| A little | 3.4 | 6.7 | 3.3 | 10.0 |
| Moderate | 17.2 | 10.0 | 10.0 | 3.3 |
| Quite a lot | 10.3 | 3.3 | 10.0 | 6.7 |
| Extremely | 6.9 | 3.3 | 6.7 | - |
| Helpless | | | | |
| Not at all | 44.8 | 56.7 | 30.0 | 46.7 |
| A little | 13.8 | 10.0 | 20.0 | 6.7 |
| Moderate | 13.8 | 16.7 | 10.0 | 26.7 |
| Quite a lot | 20.7 | 6.7 | 10.0 | 10.0 |
| Extremely | 6.9 | 10.0 | 20.0 | 10.0 |

For the depression and schizophrenia vignette table 9.4 shows the proportion of LACS with negative feelings about the vignettes. LACS generally rated themselves as not at all feeling anxious, uneasy, irritated or helpless on the post-test. An extreme desire to help with depression was reported more in the post-test (56.7%) compared to the pre-test (36.7%), while for schizophrenia a moderate desire to help was reported by all LACS on the post-test (100%) compared to 10.0% on the pre-test. Significance levels are recorded in table 9.6 and 9.8.

Table 9.5 shows the proportion of LACS that labelled potential mental health treatments as helpful or harmful. Typically LACS rated potential treatments as more helpful than harmful in the pre and post-test. However, findings from the Wilcoxon Signed Rank Test showed that pre and post-test differences for all treatment types were not statistically significant ($p < 0.05$).

Table 9.5

Proportion of LACS identifying potential treatments as helpful or harmful

| Treatment types | Depression Vignette | | Schizophrenia Vignette | |
|-----------------------------|---------------------|---------------|------------------------|---------------|
| | Pre-Test (%) | Post-Test (%) | Pre-Test (%) | Post-Test (%) |
| Vitamins | | | | |
| Helpful | 86.7 | 86.7 | 90.9 | 90.9 |
| Harmful | - | - | 9.1 | 9.1 |
| Herbs | | | | |
| Helpful | 78.3 | 69.6 | 82.4 | 76.7 |
| Harmful | 21.7 | 30.4 | 17.6 | 23.5 |
| Pain relief | | | | |
| Helpful | 26.3 | 27.8 | 38.9 | 41.2 |
| Harmful | 73.7 | 72.2 | 61.1 | 58.8 |
| Anti-depressants | | | | |
| Helpful | 65.2 | 63.6 | 83.3 | 66.7 |
| Harmful | 34.8 | 36.4 | 16.7 | 33.3 |
| Sleeping pills | | | | |
| Helpful | 47.6 | 52.4 | 63.2 | 61.1 |
| Harmful | 52.4 | 47.6 | 36.8 | 38.9 |
| Tranquilizers | | | | |
| Helpful | 6.7 | 10.0 | 29.4 | 17.6 |
| Harmful | 60.0 | 53.3 | 70.6 | 82.4 |
| Anti-psychotics | | | | |
| Helpful | 15.8 | 11.1 | 78.3 | 73.9 |
| Harmful | 84.2 | 88.9 | 21.7 | 26.1 |
| Acupuncture | | | | |
| Helpful | 81.0 | 81.0 | 82.4 | 70.6 |
| Harmful | 19.0 | 19.0 | 17.6 | 29.4 |
| Cognitive behaviour therapy | | | | |
| Helpful | 96.0 | 95.8 | 92.0 | 88.0 |
| Harmful | 4.0 | 4.2 | 8.0 | 12.0 |
| Electroconvulsive therapy | | | | |
| Helpful | - | 11.8 | 6.3 | - |
| Harmful | 60.0 | 88.2 | 93.8 | 80.0 |
| Psychiatric Ward | | | | |
| Helpful | 19.0 | 20.0 | 85.7 | 77.3 |
| Harmful | 81.0 | 80.0 | 14.3 | 22.7 |

9.5 The impact of training on mental health knowledge

Results of statistical tests for LACS pre and post questionnaire are presented in Table 9.6. The Wilcoxon Signed Rank Test evaluated the difference between the LACS pre and post training ratings on mental health. Mental health knowledge was measured by assessing; general mental health knowledge, mental health knowledge of young people, knowledge of emotional and behavioral difficulties, depression, anxiety, psychosis, symptoms and help seeking in young people. The results showed highly significant improvements following training on these items for the pre and post-test ($p < 0.05$), with mean ranks indicating increased knowledge post training. For the depression and schizophrenia vignette results indicated a significant improvement in mental health literacy for depression ($p < 0.05$), but for the schizophrenia vignette, no significant difference was found ($p > 0.05$). Total feelings about depression on the post-test were significantly more positive compared to the pre-test ($p < 0.05$), however feelings about schizophrenia pre training and post training was borderline significant ($p = 0.05$). Confidence with depression, confidence with schizophrenia and general confidence were significantly improved in the post-test ($p < 0.05$) compared to the pre-test. No significant differences were identified between pre and post training scores for total personal and perceived stigma for depression and schizophrenia ($p > 0.05$).

Table 9.6

Descriptive statistics & Wilcoxon Signed Rank Test for LACS mental health knowledge pre and post scores

| Ratings | N | Pre-Test | | Post-Test | | z | p |
|---|----|--------------|----------------|--------------|----------------|-------|------|
| | | Mean (SD) | Median (Range) | Mean (SD) | Median (Range) | | |
| General mental health knowledge | 30 | 2.73 (.828) | 3.00 (3) | 3.37 (.718) | 3.00 (3) | -3.78 | .001 |
| Mental health of young people | 30 | 2.47 (.681) | 2.00 (2) | 3.37 (.765) | 3.00 (3) | -4.01 | .001 |
| Mental health of vulnerable young people | 29 | 3.00 (.535) | 3.00 (2) | 3.69 (.604) | 4.00 (3) | -3.87 | .001 |
| Emotional and behavioral difficulties | 30 | 2.80 (.847) | 3.00 (3) | 3.43 (.774) | 3.00 (3) | -3.04 | .002 |
| Depression | 30 | 2.50 (.820) | 2.00 (3) | 3.40 (.770) | 3.00 (3) | -3.71 | .001 |
| Anxiety disorder | 30 | 2.20 (.761) | 2.00 (3) | 3.37 (.890) | 3.00 (4) | -4.09 | .001 |
| Psychosis | 30 | 1.97 (.928) | 2.00 (3) | 3.23 (.858) | 3.00 (4) | -4.32 | .001 |
| Symptoms of mental health problems | 30 | 2.40 (1.00) | 2.00 (4) | 3.57 (.774) | 4.00 (4) | -4.28 | .001 |
| Help seeking in young people for mental health difficulties | 30 | 2.60 (.855) | 2.50 (3) | 3.43 (.935) | 3.50 (4) | -3.68 | .001 |
| Total mental health knowledge | 30 | 19.67 (5.49) | 18.50 (21) | 27.17 (5.51) | 29.00 (3) | -4.47 | .001 |
| Total mental health literacy score depression | 29 | 3.93 (1.03) | 4.00 (3) | 1.37 (.440) | 1.67 (1) | -4.71 | .001 |
| Total mental health literacy score schizophrenia | 27 | 4.41 (1.21) | 5.00 (4) | 4.41 (1.33) | 5.00 (4) | -.096 | .923 |
| Total feelings about depression | 29 | 14.28 (4.81) | 13.00 (20) | 1.96 (.729) | 1.71 (3) | -4.70 | .001 |
| Total feelings about schizophrenia | 30 | 16.47 (5.62) | 16.00 (20) | 15.03 (4.65) | 14.50 (19) | -1.92 | .054 |
| Total personal stigma depression | 29 | 30.17 (3.43) | 31.00 (11) | 30.76 (3.71) | 32.00 (13) | -.789 | .430 |
| Total personal stigma for schizophrenia | 28 | 28.93 (3.36) | 29.00 (14) | 29.0 (5.55) | 30.00 (38) | -1.80 | .071 |
| Total perceived stigma depression | 30 | 17.30 (4.49) | 16.00 (19) | 15.77 (4.90) | 14.50 (21) | -1.68 | .092 |
| Total perceived stigmas schizophrenia | 30 | 17.73 (4.83) | 17.00 (28) | 16.50 (4.96) | 16.00 (21) | -1.16 | .245 |
| Confidence with depression | 30 | 3.13 (.973) | 3.00 (3) | 3.97 (.718) | 4.00 (2) | -3.74 | .001 |
| Confidence with schizophrenia | 29 | 3.03 (1.26) | 3.00 (4) | 3.59 (.946) | 3.00 (3) | -2.57 | .010 |
| General confidence | 28 | 4.46 (2.36) | 4.00 (9) | 3.36 (.731) | 3.00 (3) | -2.41 | .016 |

9.6 Impact of the training on recognition of depression and schizophrenia

Table 9.7 shows there was no improvement between the pre and post-test for recognition of depression. For the schizophrenia vignette there was an improvement, but this was not statistically significant ($p>0.05$).

Table 9.7
Proportion of LACS correctly recognizing disorder in vignette

| Type of Vignette | Pre-Test | Post-Test | P –value ¹ |
|------------------|----------|-----------|-----------------------|
| Depression | 79.3 | 79.3 | 1.00 |
| Schizophrenia | 17.9 | 32.1 | .250 |

¹McNemar test

Table 9.8 indicates that LACS ratings for feelings about depression did not differ significantly in the pre and post-test. However, for schizophrenia feelings of helplessness was significantly less in the post-test compared to the pre-test ($p<0.05$).

Table 9.8
LACS ratings on feelings about depression and schizophrenia vignette

| Ratings (feelings) | Depression Vignette | | | | Schizophrenia Vignette | | | |
|--------------------|---------------------|------------------|-------|------|------------------------|------------------|-------|------|
| | Pre-Test (N=29) | Post-Test (N=30) | z | p | Pre-Test (N=30) | Post-Test (N=30) | z | p |
| | Median | Median | | | Median | Median | | |
| Anxious | 2.00 | 2.00 | -.297 | .767 | 4.00 | 3.00 | -1.05 | .292 |
| Uneasy | 2.00 | 2.00 | -.765 | .444 | 4.00 | 3.00 | -1.47 | .141 |
| Desire to help | 2.00 | 1.00 | -1.60 | .109 | 1.00 | 1.00 | -.302 | .763 |
| Sympathy | 2.00 | 2.00 | -.215 | .830 | 1.50 | 2.00 | -.579 | .563 |
| Anger | 1.00 | 1.00 | -.740 | .459 | 1.00 | 1.00 | -.947 | .344 |
| Irritation | 1.00 | 1.00 | -1.08 | .279 | 1.00 | 1.00 | -1.66 | .095 |
| Helpless | 2.00 | 1.00 | -.891 | .373 | 2.50 | 2.00 | -2.32 | .020 |

9.8 Impact of training on personal and perceived stigma scale, pre and post-test

For perceived stigma towards depression pre and post-test ratings did not differ significantly (Table 9.9). However for personal stigma the item ‘People with a problem like Mary’s/John’s are unpredictable’ yielded a statistically significant difference between the pre and post-test for depression and schizophrenia ($p < 0.05$), with LACS showing more personal stigma on the post-test compared with the pre-test. In addition, for the schizophrenia vignette LACS reported significantly less personal stigma for the post-test item ‘John’s problem is not a real medical illness’ compared to the pre-test ($p < 0.05$).

In addition, for schizophrenia the perceived stigma scale had a statistically significant difference between the pre and post-test for item ‘Most people believe that John’s problem is not a real medical illness’, with LACS reporting less perceived stigma in the post-test ($p < 0.05$) compared to the pre-test (Table 9.9).

Table 9.9

Personal & Perceived Stigma Scale pre and post-test scores depression & schizophrenia vignettes (Wilcoxon Signed Rank Test)

| Measures | Signed rank | Depression Vignette | | | | | Schizophrenia Vignette | | | | |
|--|-------------|---------------------|-------|--------|-------|------|------------------------|-------|--------|-------|------|
| | | N | Mean | Sum | z | p | N | Mean | Sum | z | p |
| | | Rank | Rank | Rank | | | Rank | Rank | Rank | | |
| Personal Stigma Scale | | | | | | | | | | | |
| People with problems like Mary could snap out of it if they wanted to | Negative | 3 | 8.17 | 24.50 | -1.57 | .115 | 3 | 5.33 | 16.00 | -.795 | .472 |
| | Positive | 10 | 6.65 | 66.50 | | | 6 | 4.83 | 29.00 | | |
| | Ties | 16 | | | | | 19 | | | | |
| | Total | 30 | | | | | 28 | | | | |
| A problem like Mary's is a sign of personal weakness | Negative | 5 | 6.00 | 30.00 | -.302 | .763 | 4 | 5.25 | 21.00 | -.187 | .852 |
| | Positive | 6 | 6.00 | 36.00 | | | 5 | 4.80 | 24.00 | | |
| | Ties | 18 | | | | | 19 | | | | |
| | Total | 29 | | | | | 28 | | | | |
| Mary's problem is not a real medical illness | Negative | 3 | 4.67 | 14.00 | .001 | 1.00 | 7 | 4.64 | 32.50 | -2.12 | .033 |
| | Positive | 4 | 3.50 | 14.00 | | | 1 | 3.50 | 3.50 | | |
| | Ties | 22 | | | | | 20 | | | | |
| | Total | 29 | | | | | 28 | | | | |
| People with a problem like Mary's are dangerous | Negative | 2 | 4.00 | 8.00 | -1.81 | .070 | 4 | 7.00 | 28.00 | -1.27 | .204 |
| | Positive | 7 | 5.29 | 37.00 | | | 9 | 7.00 | 63.00 | | |
| | Ties | 20 | | | | | 15 | | | | |
| | Total | 29 | | | | | 28 | | | | |
| It is best to avoid people with a problem like Mary's so that you don't develop this problem | Negative | 3 | 4.67 | 14.00 | 0.001 | 1.00 | 6 | 4.08 | 24.50 | -1.89 | .058 |
| | Positive | 4 | 3.50 | 14.00 | | | 1 | 3.50 | 3.50 | | |
| | Ties | 22 | | | | | 21 | | | | |
| | Total | 29 | | | | | 28 | | | | |
| People with a problem like Mary's are unpredictable | Negative | 3 | 5.00 | 15.00 | -2.43 | .015 | 2 | 15.75 | 31.50 | -2.16 | .031 |
| | Positive | 11 | 8.18 | 90.00 | | | 15 | 8.1 | 121.50 | | |
| | Ties | 15 | | | | | 11 | | | | |
| | Total | 29 | | | | | 28 | | | | |
| If I had a problem like Mary's I would not tell anyone | Negative | 10 | 7.20 | 72.00 | -1.90 | .057 | 4 | 7.25 | 29.00 | -.780 | .435 |
| | Positive | 3 | 6.33 | 19.00 | | | 5 | 3.20 | 16.00 | | |
| | Ties | 16 | | | | | 19 | | | | |
| | Total | 29 | | | | | 28 | | | | |
| Perceived Stigma Scale | | | | | | | | | | | |
| People with problems like Mary could snap out of it if they wanted to | Negative | 7 | 7.50 | 52.50 | -.516 | .606 | 10 | 8.05 | 80.50 | -1.80 | .071 |
| | Positive | 6 | 6.42 | 38.50 | | | 4 | 6.13 | 24.50 | | |
| | Ties | 17 | | | | | 16 | | | | |
| | Total | 30 | | | | | 30 | | | | |
| A problem like Mary's is a sign of personal weakness | Negative | 13 | 11.85 | 154.00 | -1.92 | 0.54 | 8 | 8.44 | 67.50 | -.442 | .659 |
| | Positive | 7 | 8.00 | 56.00 | | | 7 | 7.50 | 52.50 | | |
| | Ties | 10 | | | | | 15 | | | | |
| | Total | 30 | | | | | 30 | | | | |
| Mary's problem is not a real medical illness | Negative | 12 | 8.83 | 106.00 | -2.13 | 0.33 | 11 | 7.27 | 80.00 | -2.48 | .013 |
| | Positive | 4 | 7.50 | 30.00 | | | 2 | 5.50 | 11.00 | | |
| | Ties | 14 | | | | | 17 | | | | |
| | Total | 30 | | | | | 30 | | | | |
| People with a problem like Mary's are dangerous | Negative | 9 | 8.39 | 75.50 | -1.47 | .142 | 9 | 8.33 | 75.00 | -.367 | .713 |
| | Positive | 5 | 5.90 | 29.50 | | | 7 | 8.71 | 61.00 | | |
| | Ties | 16 | | | | | 14 | | | | |
| | Total | 30 | | | | | 30 | | | | |
| It is best to avoid people with a problem like Mary's so that you don't develop this problem | Negative | 9 | 9.56 | 86.00 | -.956 | .339 | 9 | 7.77 | 65.00 | -.291 | .771 |
| | Positive | 7 | 7.14 | 50.00 | | | 6 | 9.17 | 55.00 | | |
| | Ties | 14 | | | | | 15 | | | | |
| | Total | 30 | | | | | 30 | | | | |
| People with a problem like Mary's are unpredictable | Negative | 10 | 9.70 | 97.00 | -.525 | .599 | 7 | 8.64 | 60.50 | -.524 | .600 |
| | Positive | 8 | 9.25 | 74.00 | | | 7 | 6.36 | 44.50 | | |
| | Ties | 12 | | | | | 16 | | | | |
| | Total | 30 | | | | | 30 | | | | |
| If I had a problem like Mary's I would not tell anyone | Negative | 6 | 8.42 | 50.50 | -.133 | .894 | 9 | 9.50 | 85.50 | -.394 | .693 |
| | Positive | 8 | 6.81 | 54.50 | | | 10 | 10.45 | 104.50 | | |
| | Ties | 16 | | | | | 11 | | | | |
| | Total | 30 | | | | | 30 | | | | |

9.9 Discussion

Overall 56.7% of LACS reported having no previous mental health training and just 1.2% received training about youth mental health problems. Thus the training appears to fill a gap in terms of youth mental health issues.

This is the first evaluation of the pilot LAC mental health training programme and although the results are preliminary, findings did demonstrate that the training was beneficial. The pilot evaluation identified some benefits of the LAC mental health training programme. Primarily the training had an impact on; knowledge about youth mental health, confidence, depression, anxiety, psychosis and help seeking in young people, with LACS scoring significantly higher on the post-test. This is encouraging because improving LACS knowledge about mental health and help seeking in vulnerable young people will enable them to work with their caseload of young people more effectively. Feelings about depression were significantly more positive after the training; this was not the case for schizophrenia. Suggesting that more work is required to improve how people respond to schizophrenia. On closer inspection, results indicated that feelings of helplessness towards schizophrenia were reduced. This may be attributed to the increased mental health knowledge and confidence which can empower LACS to confront these issues, should they arise. The post-test revealed that LACS felt less helpless, the implication of this is that LACS may feel more able to assist young people with mental health problems.

The training however was less effective in facilitating symptom recognition on the depression and schizophrenia vignette. There was no significant difference between the pre and post-test for symptom recognition. It is important that the training effectively covers symptoms associated with disorders; this will enable prompt and relevant referrals to be made. Generally potential treatments

for depression and schizophrenia were regarded as helpful by LACS, however no significant differences was found for thoughts about treatment type before and after the training. Aviram (2007) argued that service providers play a vital part in promoting service utilization. Thus a more positive attitude to available treatments is more likely to result in service promotion and more successful referrals. This links in with Gulliver et al, (2010) who argued that the behaviour of service providers can influence help seeking.

A significant difference between the pre and post-test was found for personal stigma towards depression and schizophrenia. Surprisingly, more personal stigma was reported in the post-test compared to the pre-test for unpredictability. That is, LACS rated the person depicted in the depression and schizophrenia vignette as being more unpredictable after the training. What this suggests is that the training may have emphasized the individuality and changeability of these disorders, or that LACS staffs were uncertain about what to expect from someone suffering from depression and schizophrenia. More familiarity with these disorders and with people suffering from these disorders would improve LACS's understanding.

For the schizophrenia vignette LACS were significantly less likely to agree with the statement; 'John's problem is not a real medical illness' on the post-test, indicating reduced personal stigma. Perceived stigma was also reduced for this item on the post-test compared with the pre-test, with more LACS reporting that other people see schizophrenia as a real medical illness. This is important because if these disorders are not seen as medical, people are less likely to promote or seek medical services.

9.9.1 Limitations

Results should be interpreted with caution. Due to the multiple testing Bonferonni adjustments should have been made, but this was a pilot study and findings were used to inform the next phase of research, in addition, Bonferonni adjustments have been identified as being overly conservative (Perneger, 1998).

The pre and post-test evaluated the training over a short period of time, thus we are unable to ascertain whether improvements or impact will be maintained. Furthermore samples size of LACS was limited. Another consideration is that service users who are to indirectly benefit from the training were not accessed, thus we were unable to ascertain how and if the training has benefited them.

Another limitation of the evaluation study is that results may be due to repeat testing; further research would need a waiting list control group with pre and post measures to test this.

9.10 Conclusion

This study does corroborate with previous studies which highlight the need for training LACS staff and youth workers (Stiffman, 2000; Cheng, et al, 2013). What this training succeeded in doing was increasing knowledge and confidence with mental health in LACS. It is assumed that by educating LACS about mental health, the young people they work with will be the beneficiaries of better service. Future training could emphasize topics on dispelling stigma, dealing with negative feelings and recognizing symptoms of common disorders.

Due to the aforementioned limitations and findings, follow-up telephone interviews were conducted with LACS. This is discussed in the proceeding section.

9. 11 Qualitative findings for LAC staff telephone interviews

The main objective of the telephone interviews was to assess the efficacy of the pilot LAC mental health training courses. Interview transcripts were subject to thematic analysis and several themes emerged including; value of the training, challenges, knowledge attained, and service promotion. The opinions and expressions of LAC staff are described and the implications for future training are discussed.

9.11.1 Need for training

When exploring the reasons why staff attended the training, common reasons fell into three categories; current limited training options and increased need, relevance of the training to job role and difficulties in working with young people. Participants expressed a need for mental health training, with some indicating that such training had not been previously available. This can be seen from the quotes below:

“I was quite pleased and enthused about the training because I had a statement for OFSTED and one of the things they were talking about was about staff not having enough detail about mental health training so when it came along I was put forward for it, my manager and my manager below me, I was allowed to go and so was my other manger but I was more than happy to go because it was going to be beneficial for work and for good practice...the core training which we get, we have to have mandatory training but don’t have that at any sort of level really.” (Male 52)

“I mean some staff freeze when they come across young people with mental health. If you’re going to work with people you need to know what makes them think and why they are like the way they are. It helps to deal with your work perceptively.” (Male 59)

“Obviously before the training I’ve only gone on my own little bit of knowledge, what you hear on the news, when I’ve worked with other professionals in mental health. But having a session where you’re actually being explained to and talked to, it’s a bit more, more enlightening.” (Male)

Staff also observed that mental illness was an increasingly common issue and recognised the need for more training confirming findings by Whyte and Campbell (2008):

“Over the last three or four years probably longer a lot of children are coming into care with some sort of mental health issue. ...there are more and more kids coming in with it and I think it’s one of them ones were if it’s good quality training it can’t be bettered at home.” (Male 52)

“Well I suppose there’s a greater need. If you look at stats and figures more people have been referred for depressive illness, things like that, than there was maybe 10 or 15 years ago. So the need for investment in mental health is getting bigger and bigger all the time”. (Male 46)

Secondly participants emphasised that the training was very relevant to their job role as they work with several young people experiencing mental health difficulties:

“Mental health is a significant problem with our young people so we do have a lot of experience of it. I’d say everyone seems to have somebody on their caseload that has some kind of issues they need help with. I mean I’ve got one now his actually referred himself to a psychologist because he had counseling when he was in foster care. I offered him the chance to see a mental health social worker but his referred himself. He seems to be benefiting from that, but that’s just an example of what I’ve got on my caseload...so many young people on our caseload have various mental health issues.” (Male 46)

“I work for the rights and participation service which offers one to one advocacy support for Birmingham children in care so that’s potentially any Birmingham child within the authority that is placed anywhere within the UK. So I do work with many children and young people who have either a diagnosis of mental health or learning disabilities of a variety, we work across the age range from 0 to 25. So it was of immense benefit.” (Female 40)

Thirdly, LAC staff expressed negative feelings and frustration dealing with young people prior to the training; some staff expressed feeling anger, fear and being worried when working with young people:

“In the past I used to...feel probably angry at the way they’re acting and so on. Now it’s different, somebody who has got a mental health issue might come up to you with aggressive behaviour and of course you’d defuse that...rather than just getting angry or turning your back.” (Female 41)

(Before the training) “Not informed, a bit weary, maybe putting all mental health issues under the same umbrella when there are so many different ones and being a bit impatient with people with mental health issues, thinking perhaps they should pull themselves together.” (Female 40)

“I was frightened because I didn’t know; I’m not an expert in it. So I’d either look for someone else or try and avoid it...wouldn’t be afraid to do it now.” (Female 40)

In comparison, when LAC staffs were asked about their work after the training, they reported experiencing better working relationships with young people and spending more time with them. Staff often attributed this to a better understanding and being more informed due to the training:

“We have a better working relationship, now that I have the understanding; I was able to assist the young person to understand what was happening with her. She also knew there was something wrong but she was hiding from it. But the fact that I was able to support her more with my understanding helps her to understand what might be happening with her. That’s how we managed to move forward and have a better working relationship.” (Male 29)

“obviously if they get a worker who is more informed and you know understands it’s going to be better for them, they’re going to forge better working relationships, feel more confident, feel listened to and improve their self confidence...make them feel they are not a freak or there’s nothing wrong with them. So hopefully it will just foster better working relationships.” (Female 40)

*“It was much better, because I think I actually felt listened to as supposed to us telling them.”
(Female 56)*

“I take longer with them, much longer, were as I used to bat them off, or I used to think I’ve got this certain amount of time to do that. So you literally have got to stand up and say it doesn’t matter the time I’m spending with you.” (Female 56)

9.11.2 Acquisition of knowledge and skills

LAC staff spoke extensively about how the training improved their knowledge of youth mental health. Specifically LAC staff mentioned being more knowledgeable about schizophrenia after the training. Knowledge acquisition included two subthemes; skills and understanding disorders.

Firstly, general quotes reflecting knowledge acquisition are presented below:

“Like I said I didn’t know about schizophrenia before, and how to react to those people, I didn’t know that. I mean I had a slight idea about ADHD and all of those cause I’ve worked with a lot of young people, but ...I didn’t have a clue.” (Female 56)

“you hear the phrase schizophrenic and everyone thinks you know, its multiple personality, we sort of went a bit in detail about what that actually means and more so about what life’s like with someone with schizophrenia. It was interesting in that respect.” (Female 40)

“I had minimum knowledge of how to work with young people with mental health issues, but now I have much more knowledge and am able to support them better...Its updated me on certain conditions, there are conditions you know about like schizophrenia that’s the first thing you think of, but it’s given me more insight on simpler conditions cause it’s not always schizophrenia or severe depression. It’s given me insights on certain other aspects of mental health.” (Male 29)

Additionally, some participants felt the training developed their existing knowledge and kept them up to date with terms and mental health information:

“It’s updated my knowledge and updated my understanding of more specific cases of young people in care that I’m now dealing with and the history I suppose understanding how a person’s history will have an impact on their behaviours and factoring that more into interactions and responses young people might be giving.” (Male 59)

“I’ve learnt about new terminologies to bring me up to date because certain things were foreign to me. I did find it useful...it’s not as if I was a 4 and it leaped to a 10 you know my knowledge was sort of baseline anyway and then it just built a little bit on that knowledge.” (Female 43)

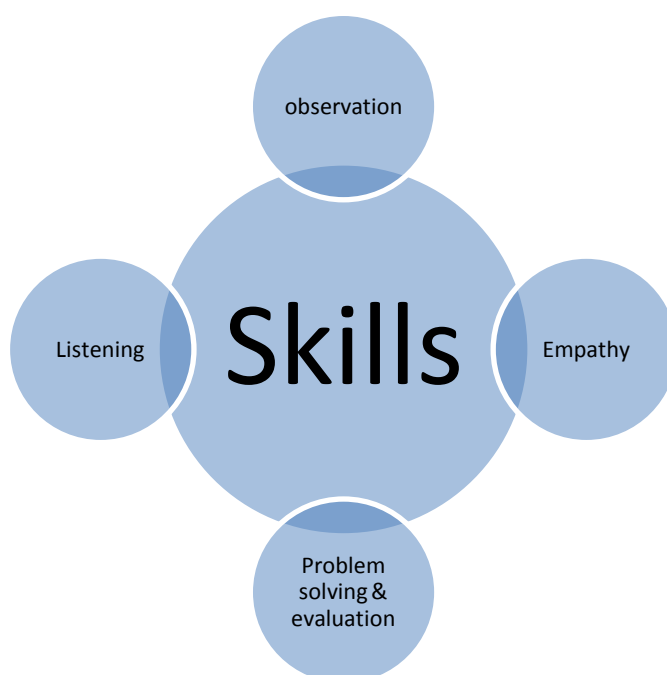
“Re-tapping what knowledge I’ve got and also the up to date knowledge of the law and the scenarios they used were really useful.” (Female 40)

Overall participants did report more mental health knowledge after the training, while other staff felt the training was successful in keeping them updated.

9.11.3 Skills

As part of their knowledge acquisition LAC staff revealed that the training enhanced their skill set. The skills frequently mentioned are summarised in Figure 9. 1.

Figure 9.1 Skills developed as a result of the training



9.11.4 Understanding

Some LAC expressed being more understanding about the challenges young people face, and realised that young people were often dealing with conditions and not just acting out:

“another young person with autism and has got anxiety and depression...is really difficult to work with because he’s so argumentative...I found it really challenging working with him...But I understand it’s not him purposely wanting to be difficult, It’s his condition. (I) see him as really vulnerable really because this condition makes life so difficult for him.” (Female 40)

“this young lady has got bipolar...you can say one thing one day and she’s fine; another day, another time, ten minutes later she’s not...But it’s getting her to have confidence in the systems in place and understanding that you know if a young person is having an issue or an episode it’s not a reflection on them.” (Male 52)

It appeared that understanding mental illness in young people facilitated the recognition of signs and symptoms of mental health problems in young people, resulting in young people receiving better support.

“It helped me to understand the mindset of some of the young people we work with. Some of the conditions you could actually put a name to a condition, when we are working with young people we can say that there’s something wrong but you could never, you know when you can put your finger on it, it just made more sense after that training and we could deal with our young people more competently.” (Male 29)

“It was useful because also we went into a little bit about various illnesses and how people are feeling and just giving us an understanding about mental illness and looking at the signs and the symptoms...I can remember, if some of the symptoms are going on for more than three months or six weeks...then you know that it’s a little bit more serious...that’s why I feel that the training was relevant so that we can kind of pick on the signs and recognise if something is wrong and someone is needing extra support.” (Female 43)

9.11.5 Improved confidence

When asked about confidence, the majority of responses suggested that LAC staff felt more confident after the training, when working with young people:

“Very confident, usually I’m quite confident but more so after the training definitely. Because I thought is it me? Am I clashing? Because I’m not the right worker for them. You know is it a personality clash? And it did knock my confidence working with them a bit.” (Female 40)

“All my thoughts and feelings were always to help the young people but I never had the confidence to do it before, but now I have more confidence.” (Male 29)

“I genuinely feel that people feel a bit more confident not saying that that’s competence, but I think for some people it’s probably a new area, I think they feel a little more confident now” (Female 43)

9.12 Referrals

When staffs were asked about the referral process, they reported that the training provoked an increase in the number of referrals, with LAC staff being more understanding, thoughtful and confident when making referrals, rather than overlooking issues:

It does help you think about what you’re doing and I think referrals will increase because of that...What the training reassured me of was that it’s ok to make a referral, it’s ok to think there might be a concern or issue and handing it to someone else who will make that full assessment (Female 41)

“I think it’s slightly increased it, if we were to statistically count. I have heard more people making referrals yes, and it’s certainly provoked thought amongst the staff, about thinking it’s a mental health issue rather than a behavioural issue...It sort of provoked more conversation about whether a mental health issue is a possibility rather than other factors such as being influenced by peers or behavioural problems or issues or whatever. So I think the main thing is it provoked thought and increased referrals.” (Female 31)

“I’d just give it more thought more so than dismissing the situation, a bit more thought what I could do. Although I couldn’t do much, it’s more about referring them to the right agencies that can help.” (Male 57)

“I used my new understanding I should say, to work with a young person with I’d say severe depression...so with the knowledge I gained, I was able to use it to work with her, to recognise her condition and then we made a step forward to making a referral and now she’s having counseling.” (Male 29)

9.13 Promoting the mental health service & signposting

Since the training several LAC staff reported promoting the services which they were informed of during the training and they mentioned that the training enhanced networking and interagency working:

“The new website, I didn’t know about that website before so I’ve been promoting that to young people. Because yes it talks about mental health but it talks about other things as well. For young people, young people issues. So...what I brought away from the training really is learning about the website” (Female 43)

“We were given lots of contacts for different services and more familiarised with Choose Youth and the brilliant service that they offer to children and young people and an awareness of the new 16+ care leavers mental health service, which obviously a lot of our young people we can signpost to or work alongside that service within the rights and participation advocacy.” (Female 40)

“It was useful because it brought us together as a team and other individuals from other teams, for one reason networking.” (Male)

Despite having more awareness of services and promoting them, LAC staff voiced several challenges faced by the LAC mental health service (Table 9.10).

Table 9.10 Challenges for LAC mental health services

| Challenges | Quotes |
|---|--|
| Youth disengagement | “When they’re lacking motivation to go out, even to make a GP appointment and you’ll say to them yes I’m here, do you want me to take you? And they’ll say no. You go on another visit, say have you been? They’ll say no I haven’t! And you’re thinking to yourself well you can’t force anyone to seek help.” (Female 43) |
| | “But just being able to make that referral, because before she just kept refusing. And when I’ve made the referrals without her knowledge, she used to hide everything.” (Male 29) |
| Restricted criteria | “Cause she didn’t have the criteria she was due to go down the route of a mainstream 18+ care leaver which would have been going to St Basils... We do find that young people who are kind of on the borderline or not having a clear diagnosis it’s a struggle to get them the placements.” (Female 40) |
| | “If CAMHS stops at 16 or 18 even though we call our care leavers young people actually they’re adults that’s where things get a bit confusing. Being called an 18 year old adult or are they still a young person? Because if they are still a young person then they should have a specific young person’s facility.” (Male 46) |
| Staff training expenses | “I’ve had a paper come through last week and we’ve got more staff that can go on this training but it’s pretty quite expensive...It is going to roll out but it’s quite a major expense to my understanding.” (Male 52) |
| Referral process | “The only problem I have with a referral is that they take so long. It doesn’t happen straight away and that’s where your sticking point is because obviously there’s budget cuts and stuff like that.” (Male 52) |
| | “They don’t like referrals cause it’s a stigma to them CAMHS.” (Female 56) |
| Poor mental health literacy in young people | “She was still in denial... didn’t recognise there was a problem.” (Male 29) |
| | “When you mention the word mental health they think oh am not mad, am mad, you’re calling me mad... Its lack of knowledge.” (Male) |

9.14 Overall Feedback

In terms of the training course, participants generally felt very positive about the experience and many participants were impressed with the facilitators and the delivery of the training.

“I thought it was very well constructed well put together. There’s nothing I could criticise about it at all, because it’s one of the first few courses I’ve been on were from the start to the end I was captivated by it. And everything was interesting and relevant to what they were teaching. I remember some courses you go on and your dozing half way through. It was very stimulating, very thought provoking, makes you look at your own practice and how you can improve what you do” (Male 52)

In particularly, many LAC staff highlighted a hearing voices exercise as having a positive impact and providing them with much needed insight about psychotic like symptoms,

“we did an exercise about hearing voices and that was a powerful exercise because you had one person asking you questions and another person whispering in your ears and you had to try and concentrate on the question the other person was asking you and that really gave us an insight as to what it’s like for someone to hear voices...going through that exercise to me was powerful because it torments you it’s there constantly and to have a young person experiencing that while you’re working with them, it just gives you a little bit of understanding” (Female 43)

Some staff mentioned areas in which the training could improve,

“Maybe they could have incorporated some of the young volunteers from Choose Youth to co-facilitate the training.” (Female 40)

“I think it would be helpful to have refresher courses or more in-depth courses if they are available I’d defiantly take them up.” (Female 40)

One colleague mentioned the need for *“more focus on attempted suicide”*. In addition throughout the interviews suicide and self harm were the most frequently mentioned disorders by LAC staff:

“Young people come in here with all different symptoms, their either self harming or their threatening suicide” (Female 56)

“You might have a young person who is suicidal and that worker may find it difficult knowing that there going home and the person that their working with has got suicidal thoughts.” (Female 43)

“We have some people who have tried to commit suicide or have thought about it or expressed verbally that they might do it.” (Male 46)

“We deal with self harm, kids with scars the whole spectrum of kids, all kinds” (Female F41)

9.15 Discussion

The LAC training was found to have benefited participants who indicated that they acquired greater knowledge and benefited from networking with other staff and other organisations. This finding supports the quantitative findings, which identified statistically significant improvements in knowledge based on a pre and post-test. The training elicited a better understanding of schizophrenia according to staff comments, however mental health literacy was not significantly improved for schizophrenia on the post-test. What this suggests is that improvements voiced by participants may be due to understanding rather than specific knowledge about schizophrenia. For some LAC staff the training served as a refresher. Most LAC staff mentioned having better understanding of mental illness, which seemed to yield empathy and more patience with young people. LAC staff also stated that they had better working relationships with young people; this may result in better youth engagement and service provision.

After the training LAC staff mentioned having more confidence, this is in line with quantitative results, which found a significant improvement in confidence ratings. It appears that the improved knowledge and confidence in LAC staff resulted in more referrals, which may result in earlier access to treatment. It is worth noting that on the post-test staff felt significantly less helpless, this

might explain the increase in referrals as they were more able to help. Another point is that LAC staff signposted services that were highlighted during the training, such as, the 16+ care leaver service and Choose Youth and Youthspace.me website, thus encouraging service uptake in young people.

Overall staff gave positive feedback about the course. It was suggested that the training should be rolled out to all staff and run periodically as a refresher course. Suicide and self harm were commonly mentioned, thus more training in this area may be required.

9.15.1 Recommendations

Form the qualitative findings barriers to youth mental health services were identified by LAC staff, these barriers highlighted areas for future research and improvement. Strategies should include:

1. Reducing youth disengagement by improving working relationships between LAC staff and youth.
2. Making the referral process more youth friendly and providing specific services and pathways for young people who do not meet CAMHS criteria or have borderline mental health difficulties.
3. Providing consistent cost effective mental health training for LAC staff, particularly suicide and self-harm.
4. Improving youth mental health literacy to reduce the stigma associated with these services.

10 GENERAL CONCLUSIONS

With the increased difficulties faced by care leavers and NEET young people, this study assessed and underlined the level of mental health need in these vulnerable young people. This study fills a gap in research by providing more understanding of the psychological profile of care leavers and NEET young people. Results indicated that care leavers and NEET young people experienced more mental health difficulties compared with a community sample. Half of the care leaver sample reported having emotional difficulties and the NEET sample commonly reported peer problems. For both groups depression was least prevalent. However, there has been a wide consensus that social disengagement, social isolation and unemployment can lead to depressive symptoms (Oswald, 1997 & Creed and Reynolds, 2001). Furthermore, LAC have been found to suffer from depression which carries on into adulthood (Cheung & Buchanan, 1997). This study however puts the emphasis on emotional and peer difficulties as areas of substantial need. In addition, significantly high incidence of psychotic like experiences were reported by care leavers and NEET young people compared to controls. In addition, symptoms were rated as significantly more severe by the vulnerable groups compared to controls. The increased PLE in care leavers and NEET young people is an indicator of vulnerability to developing psychosis. Although care leavers and NEET young people clearly experience greater difficulties, they did not differ significantly from controls for willingness to seek help. Naturally increased need should result in more help seeking, however this was not the case; an explanation for this might be that young people have poor mental health literacy, which becomes a barrier to help seeking (Gulliver, et al, 2010).

When focus groups were conducted with young people, findings suggested that they had difficulty expressing their thoughts about mental health and when they did comment on mental health they

revealed stigmatising attitudes. Some young people shared negative experiences with mental health services and revealed mistrust towards mental health treatments. Young people who illustrated their thoughts about mental illness painted a very bleak picture, with such negative perceptions, it is not surprising that help seeking is suppressed in young people. This exposes an area for further research and intervention, in which young people receive mental health education and gain new perspectives.

Those that come in contact with vulnerable young people have a significant part to play, to ensure that vulnerable young people receive the necessary help. Thus when a pilot mental health training course was rolled out to staff working with LAC and care leavers, the effectiveness of the training was evaluated. Findings demonstrated that the training had a positive impact on working with young people. Staffs were more confident, patient and understanding. They reported more networking and utilized sources learned in the training to signpost young people to relevant services; indicating more effective inter agency working, which ultimately will benefit the young person. Quantitative findings indicated a significant improvement in knowledge acquisition after the training. Being more knowledgeable about mental health meant that staff mentioned making more referrals, an indication that they were more aware and confident with the referral process. This is likely to result in fewer delays for mental health assessments and timely treatment. One area of improvement and further research is symptom recognition, as after the training symptom recognition did not significantly improve, suggesting that more in-depth disorder specific training may be required.

If mental health services are to be more youth friendly staff will need to foster a positive relationship with young people, which comes with understanding. A number of staff felt they

understood the young person after the training and thus showed more empathy. It would appear that training staff who work with vulnerable youth is an effective intervention strategy. This yields positive results all round, staff become more competent resulting in better job satisfaction and young people are likely to receive better service and support.

10.1 Future research

Future research can implement and evaluate strategies to counter peer difficulties in NEET young people and emotional difficulties in care leavers. Improving how young people perceive mental health will be valuable, in terms of encouraging service utilisation. Lastly more emphasis should be placed on training youth workers and outreach workers, who come in contact with vulnerable young people on a regular basis. This has been shown to improve how staffs relate with young people and increase referrals to specialised mental health services. Research investigating the nature of these referrals will be useful for improving the referral process.

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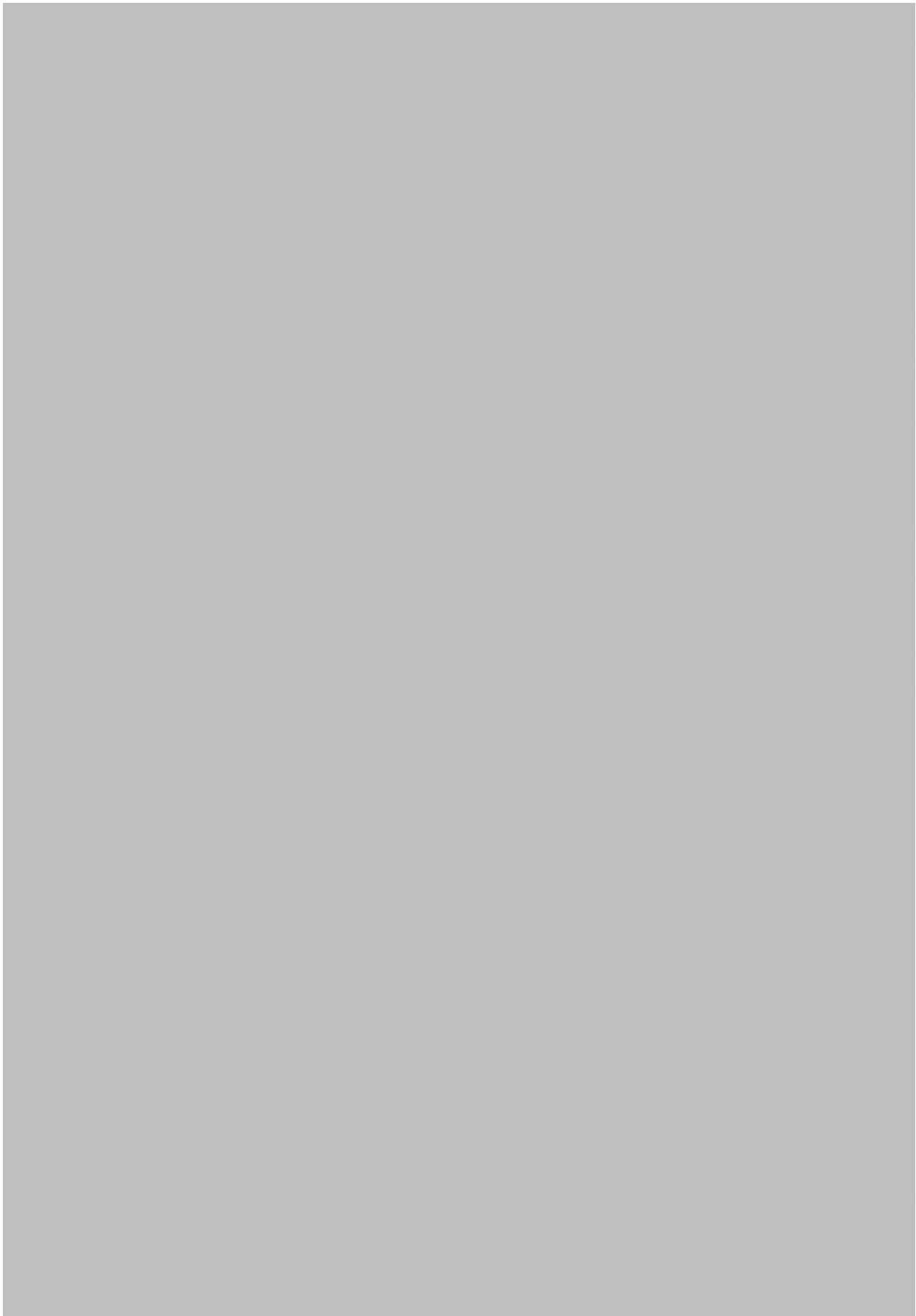
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APPENDICES

APPENDIX 1: ETHICS APPROVAL





APPENDIX 2: INFORMATION SHEET



Information Sheet

You are invited to take part in the research study: 'Mental Health Needs in Vulnerable Youth Populations'

I am a PhD student at Birmingham University, supervised by Professor Max Birchwood and CLAHRC Project Leader Paul Patterson. The study will also be collaborating with the healthy schools initiative and the CLAHRC Youth Project. Your involvement in the study will mean mental health services can be developed and improved for young people such as yourself. The research will be investigating mental health and wellbeing in young people. The research aims to identify help seeking behaviour, mental health status and knowledge in young people from different settings.



Main aims:

- To provide information on adolescent mental health and improve services
- To increase mental health awareness
- To identify ways of engaging young people so their help seeking is improved

Involvement in the study will be to take part in a focus group or questionnaires in order to assess your mental health status, knowledge and attitudes. All information that is collected during the course of the research will be kept strictly confidential. Data collected will be anonymous and confidential.

The summarised results of the study will be used in my PhD thesis and in reports to health services. The material will be presented at academic and professional conferences and in academic journals. Findings from this study will contribute to developing a better understanding mental health in young people and provide a direction towards engaging young people in schools and primary care.

Your input will be greatly appreciated, thank you and I look forward to hearing from you. [Contact details:](#)

Jennifer Irabor



APPENDIX 3: CONSENT SHEET



PARTICIPANT CONSENT FORM

Participant Number:

Title of the project: **Mental Health Needs of Vulnerable Youth Populations**

Please indicate consent by ticking the boxes.

I agree to take part in the above research. ☐

I have read the Participant Information Sheet, which is attached to this form. ☐

I understand what my role will be in this research,
and all my questions have been answered to my satisfaction. ☐

I understand that I am free to withdraw from the research at any time,
for any reason and without prejudice. ☐

I have been informed that the confidentiality of the information I provide
will be safeguarded. ☐

I am free to ask any questions at any time before and during the study. ☐

I have been provided with a copy of this form and the Participant Information Sheet. ☐

Data Protection: I agree to the University of Birmingham processing personal data that I have
supplied. ☐

I agree to the processing of such data for any purposes connected with the Research Project. ☐

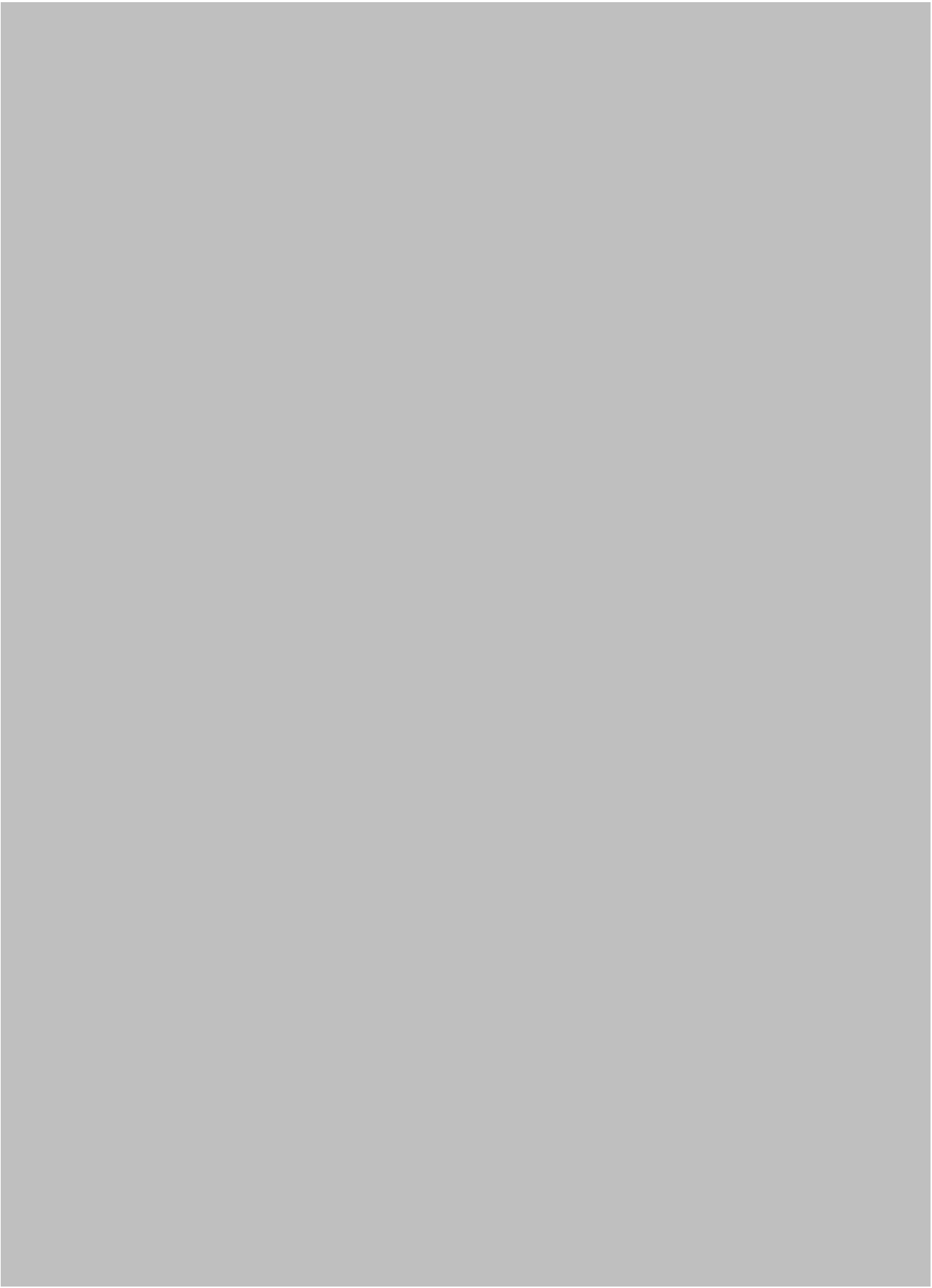
Name of participant (print).....Signed.....Date.....

Name of researcher (print).....Signed.....Date.....

APPENDIX 4: SDQ

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APPENDIX 5: HADS





APPENDIX 6: PROD





APPENDIX 7: GHSQ/AHSQ

General Help-Seeking Questionnaire





APPENDIX 8: TRAINING EVALUATION QUESTIONNAIRE

EVALUATION OF THE LAC TRAINING SELF-REPORT QUESTIONNAIRE

Please note that we require these details in order to contact you for the follow up questionnaire/ interviews in 6 weeks-3months. These details will be kept confidential.

Date: Name:

Job title: Length of time in post (yrs / months):

Work Address:

.....

..... Post-code:

Phone: Email:

Please indicate which stage of the LAC training you're in?

Stage 1 (About to start training) ☐ Stage 2 (Just completed training) ☐ Stage 3 (three month follow up) ☐

Sociodemographic information

1. What gender are you? Female ☐ Male ☐

2. Age _____

3. How would you describe your ethnic origin?

White

A British ☐

B Irish ☐

C Any other white background ☐

Mixed

D White and black Caribbean ☐

E White and black African ☐

F White and Asian ☐

G Other mixed background ☐

Asian or Asian British

H Indian ☐

J Pakistani ☐

K Bangladeshi ☐

L Other Asian background ☐

Please specify.....

Black or black British

M Caribbean ☐

N African ☐

P Any other black background ☐

Other ethnic groups

R Chinese ☐

S Other ethnic groups ☐

Please specify

Z Not stated ☐

4. Have you had any previous mental health training?

Yes ☐ No ☐

If yes, please describe this training: _____

5. Please circle the number that represents how knowledgeable you are about the following issues:

| Issues | Not at all | A little | Moderately | Quite a lot | Extremely |
|---|------------|----------|------------|-------------|-----------|
| Mental health in general | 1 | 2 | 3 | 4 | 5 |
| Mental health in young people | 1 | 2 | 3 | 4 | 5 |
| Emotional and behavioural difficulties | 1 | 2 | 3 | 4 | 5 |
| Depression | 1 | 2 | 3 | 4 | 5 |
| Anxiety disorder | 1 | 2 | 3 | 4 | 5 |
| Psychosis | 1 | 2 | 3 | 4 | 5 |
| Symptoms of mental health problems | 1 | 2 | 3 | 4 | 5 |
| Help seeking in young people for mental health difficulties | 1 | 2 | 3 | 4 | 5 |

A The following section concerns a hypothetical young person called Mary. The description below outlines how she has been recently.

Mary is a 17 year old who has been feeling unusually sad and miserable for the last few weeks. She is tired all the time; she has trouble sleeping nearly every night. Mary doesn't feel like eating and has lost weight. She can't keep her mind on her studies and she puts off making any decisions. Even day-to-day tasks seem too much for her. This has come to the attention of Marys tutor, who is concerned about her absence at college.

6. Please circle the numbers below that represent how Mary's description makes you feel

| Feeling | Not at all | A little | Moderately | Quite a lot | Extremely |
|-------------------|------------|----------|------------|-------------|-----------|
| a) Anxious | 1 | 2 | 3 | 4 | 5 |
| b) Uneasy | 1 | 2 | 3 | 4 | 5 |
| c) Desire to help | 1 | 2 | 3 | 4 | 5 |
| d) Sympathy | 1 | 2 | 3 | 4 | 5 |
| e) Anger | 1 | 2 | 3 | 4 | 5 |
| f) Irritation | 1 | 2 | 3 | 4 | 5 |
| g) Helpless | 1 | 2 | 3 | 4 | 5 |

7. (a)What, if anything, do you think is wrong with Mary?

7. (b) How do you think Mary could be best helped?

8. Imagine Mary is a young person you know. You want to help her. What would you do?

9. How confident would you currently feel in helping Mary?

- Not at all ☐
- A little ☐
- Moderately ☐
- Quite a lot ☐
- Extremely ☐

10. If Mary requires treatment indicate which type of treatment is helpful or harmful

| Type of treatment | Helpful | Harmful |
|---------------------------------|---------|---------|
| Vitamins | | |
| Herbal medicine | | |
| Pain relief medication | | |
| Antidepressants | | |
| Sleeping pills | | |
| Tranquilizer | | |
| Antipsychotics | | |
| Acupuncture | | |
| Cognitive Behavioural Therapy | | |
| electroconvulsive therapy | | |
| Admission into psychiatric ward | | |

11. The next few questions contain statements about Mary's problem. Please indicate how strongly YOU PERSONALLY agree or disagree with each statement.

| | Strongly agree | Agree | Neither agree nor disagree | Disagree | Strongly disagree |
|--|----------------|-------|----------------------------|----------|-------------------|
| a) People with problems like Mary could snap out of it if they wanted to | | | | | |
| b) A problem like Mary's is a sign of personal weakness | | | | | |
| c) Mary's problem is not a real medical illness | | | | | |
| d) People with a problem like Mary's are dangerous | | | | | |
| e) It is best to avoid people with a problem like Mary's so that you don't develop this problem | | | | | |
| f) People with a problem like Mary's are unpredictable | | | | | |
| g) If I had a problem like Mary's I would not tell anyone | | | | | |

12. Now we would like you to tell us what you think MOST OTHER PEOPLE believe. Please indicate how strongly you agree or disagree with the following statements.

| | Strongly agree | Agree | Neither agree nor disagree | Disagree | Strongly disagree |
|---|----------------|-------|----------------------------|----------|-------------------|
| a) Most people believe that people with a problems like Mary's could snap out of it if they wanted to | | | | | |
| b) Most people believe that a problem like Mary's is a sign of personal weakness | | | | | |
| c) Most people believe that Mary's problem is not a real medical illness | | | | | |
| d) Most people believe that people with a problem like Mary's are dangerous | | | | | |
| e) Most people believe that it is best to avoid people with a problem like Mary's so that you don't develop this problem | | | | | |
| f) Most people believe that people with a problem like Mary's are unpredictable | | | | | |
| g) If they had a problem like Mary's most people would not tell anyone | | | | | |

B The following section concerns a hypothetical young person called John. The description below outlines how he has been recently.

John is a 16 year old who lives at home with his auntie. He has had a few temporary jobs since finishing school but is now unemployed. Over the last six months he has stopped seeing his friends and begun locking himself in his bedroom and refusing to eat with the family or to have a bath. His auntie and other members of the household hear him walking about in his bedroom at night while they are in bed. Even though they know he is alone, they have heard him shouting and arguing as if someone else is there. When they try to encourage him to do more things, he whispers that he won't leave home because he is being spied upon by the neighbour. They realize he is not taking drugs because he never sees anyone or goes anywhere.

13. Please circle the number below that represent how John's description makes you feel

| Feeling | Not at all | A little | Moderately | Quite a lot | Extremely |
|-------------------|------------|----------|------------|-------------|-----------|
| a) Anxious | 1 | 2 | 3 | 4 | 5 |
| b) Uneasy | 1 | 2 | 3 | 4 | 5 |
| c) Desire to help | 1 | 2 | 3 | 4 | 5 |
| d) Sympathy | 1 | 2 | 3 | 4 | 5 |
| e) Anger | 1 | 2 | 3 | 4 | 5 |
| f) Irritation | 1 | 2 | 3 | 4 | 5 |
| g) Helpless | 1 | 2 | 3 | 4 | 5 |

14 (a) What, if anything, do you think is wrong with John?

14 (b) How do you think John could be best helped?

15. Imagine John is a young person you know. You want to help him. What would you do?

16. How confident would you feel in helping John?

- Not at all ☐
- A little ☐
- Moderately ☐
- Quite a lot ☐
- Extremely ☐

17. If John requires treatment indicate which type of treatment is helpful or harmful (please tick one box for each)

| Type of treatment | Helpful | Harmful |
|---------------------------------|---------|---------|
| Vitamins | | |
| Herbal medicine | | |
| Pain relief | | |
| Antidepressants | | |
| Sleeping pills | | |
| Tranquilizer | | |
| Antipsychotics | | |
| Acupuncture | | |
| Cognitive Behavioural Therapy | | |
| electroconvulsive therapy | | |
| Admission into psychiatric ward | | |

18. The next few questions contain statements about John's problem. Please indicate how strongly YOU PERSONALLY agree or disagree with each statement.

| | Strongly agree | Agree | Neither agree nor disagree | Disagree | Strongly disagree |
|--|----------------|-------|----------------------------|----------|-------------------|
| a) People with problems like John could snap out of it if they wanted to | | | | | |
| b) A problem like John's is a sign of personal weakness | | | | | |
| c) John's problem is not a real medical illness | | | | | |
| d) People with a problem like John's are dangerous | | | | | |
| e) It is best to avoid people with a | | | | | |

| | | | | | |
|--|--|--|--|--|--|
| problem like John's so that you don't develop this problem | | | | | |
| f) People with a problem like John's are unpredictable | | | | | |
| g) If I had a problem like John's I would not tell anyone | | | | | |

19. Now we would like you to tell us what you think MOST OTHER PEOPLE believe. Please indicate how strongly you agree or disagree with the following statements.

| | Strongly agree | Agree | Neither agree nor disagree | Disagree | Strongly disagree |
|---|----------------|-------|----------------------------|----------|-------------------|
| a) Most people believe that people with a problems like John's could snap out of it if they wanted to | | | | | |
| b) Most people believe that a problem like John's is a sign of personal weakness | | | | | |
| c) Most people believe that John's problem is not a real medical illness | | | | | |
| d) Most people believe that people with a problem like John's are dangerous | | | | | |
| e) Most people believe that it is best to avoid people with a problem like John's so that you don't develop this problem | | | | | |
| f) Most people believe that people with a problem like John's are unpredictable | | | | | |
| g) If they had a problem like John's most people would not tell anyone | | | | | |

20. Over the past 6 weeks:

a) Have you had contact with anyone with a mental health problem?

Never ☐ Once ☐ A few times ☐ Many times ☐

b) If no, when did you last have contact with someone with mental health problems (if applicable)?
 _____ week(s) ago

21. Please **TICK your current level of confidence** in supporting young people with mental health problems, with 0 being the lowest level of confidence

| Lowest | | | | | Highest | | | | | |
|--------|---|---|---|---|---------|---|---|---|---|----|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | | | | | | | | | | |

22. Please TICK your level of knowledge about mental health in vulnerable young people

| None | Poor | Limited | Good | Excellent |
|------|------|---------|------|-----------|
| | | | | |

THANK YOU FOR YOUR PARTICPATION